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: South of Scotland

Case ref: 201306190, Borders NHS Board
Sector: Health
Subject: Admission; discharge; transfer procedures

Summary
Mrs C complained about the way her late mother Mrs A had been treated while in hospital. Mrs A, who had dementia, was admitted to Borders General Hospital on 20 November and discharged on 4 December 2012. She was readmitted on 6 December and then discharged again on 17 December 2012. Mrs C was concerned about aspects of her mother's treatment while in hospital and that she was discharged too soon. She felt that Mrs A had been treated poorly because of her cognitive impairment. I sought independent expert advice from a nursing adviser and a medical adviser. I did not find that Mrs C had been deliberately discriminated against because of her dementia. However, my investigation identified a significant number of failings in her care, many of which related to a failure to provide appropriate care and support to someone with cognitive impairment or to follow the legislation that provides protection for someone with cognitive impairment who requires medical treatment. As a result of these failings, it is likely that, taken together, the failings were such that Mrs A's rights as an NHS patient and a dementia patient were infringed.

Care seemed to be poorly led and coordinated. There was no evidence of a full care plan and, despite the fact that she had been admitted to the hospital because of a fall and had five falls during her stay, there was no completed falls assessments in the clinical records or any evidence of a falls prevention plan. There was limited evidence of the involvement of medical staff and communication with the family was sporadic and poor. Pain and nutritional assessments were inadequate. There was also a specific incident of which I am critical when Mrs A required but was not provided with adequate pain relief and this meant her journey to the care home on 4 December was very uncomfortable. While the report identifies a number of medical and nursing failures, I did not uphold a complaint about physiotherapy and occupational therapy. There was evidence in the records of appropriate physiotherapy involvement and while I am critical that an occupational therapy assessment was only carried out after prompting by the care home, I found that overall care in these areas had been reasonable.

Redress and recommendations

The Ombudsman recommends that that Board:	*Completion date*
(i) monitor practice to ensure national dementia standards are being met including specifically that the presence of cognitive impairment is given due regard in the planning of care, and that the level of observation, supervision and provision of support provided to people with delirium and/or dementia is appropriate for their impaired capacity;	20 June 2015
(ii) ensure that staff comply with adults with incapacity legislation, in particular completing section 47 certificates and accompanying care plans;	20 June 2015
(iii) take steps to ensure communication with relatives and carers of patients with cognitive impairment is proactive and systematic;	20 June 2015
(iv) ensure that falls prevention clinical practice is administered within the Hospital in line with recognised good practice and Board policy;	20 June 2015
(v) ensure that nutritional care is carried out in line with national policy and that nutritional care plans are developed, implemented and evaluated for each patient as appropriate;	20 June 2015
(vi) explore all options to implement an observational pain assessment tool for use with patients with cognitive impairment;	20 June 2015
(vii) undertake an audit of record-keeping in wards caring for patients with cognitive impairment to ensure compliance with record-keeping guidelines and a reasonable standard of practice;	20 July 2015
(viii) review their discharge policy to ensure: its continued relevance in light of the failings arising from this case; it meets the needs of people with cognitive impairment and the need to fully involve the family in decision-making; a more systematic approach to discharge planning; and pre-discharge assessments are clearly identified at an early stage and carried out within a reasonable time to inform	20 July 2015

	follow-up care;	
(ix)	ensure the failures identified are raised as part of the annual appraisal process of relevant staff and address any training needs particularly in relation to falls prevention and adults with incapacity legislation; and	20 June 2015
(x)	apologise to Mrs C for the failures this investigation identified.	20 June 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Main Investigation Report

Introduction

1. Mrs A, who suffered from dementia and resided in a care home, was admitted to Borders General Hospital (the Hospital) on 20 November 2012 with a fracture of her left femur (thigh bone). She underwent an operation that day. Following rehabilitation, she was discharged back to the care home on 4 December 2012. However, she was readmitted on 6 December 2012 with hip pain and discharged again on 17 December 2012. Mrs A died on 3 May 2013.

2. Mrs A's daughter (Mrs C) complained that Mrs A had a number of falls during her admissions and raised concerns that staff were not sufficiently trained to deal with patients with cognitive impairment. As a result, she said Mrs A did not receive the same level of post-operative care as patients without cognitive impairment. Mrs C was also concerned that Mrs A was not fit to be discharged on 4 December 2012, and that nursing staff's communication about the discharge was not reasonable.

3. The complaints from Mrs C which I have investigated are that Borders NHS Board (the Board):

(a) failed to provide a reasonable standard of nursing care and treatment to Mrs A (*upheld*);
(b) failed to provide a reasonable standard of medical care and treatment to Mrs A (*upheld*); and
(c) failed to provide a reasonable standard of physiotherapy and occupational therapy care and treatment to Mrs A (*not upheld*).

4. Mrs C complained to the Board in late December 2012. The Board responded on 25 February 2013 and 14 November 2013. Mrs C was unhappy with their response and brought her complaint to us on 31 March 2014.

Investigation

5. During the course of the investigation of this complaint, my complaints reviewer obtained and examined a copy of Mrs A's clinical records and the Board's complaint file. She obtained independent advice on the clinical aspects of the complaint from advisers who specialise in mental health (the Nursing Adviser) and care of the elderly (the Medical Adviser).

6. 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.

Clinical background

7. Mrs A was diagnosed with a vascular type dementia and had associated receptive and expressive dysphasia which affected her ability to use and understand language. (Mrs A also had type II diabetes and was partially deaf.) She resided in a care home and on 20 November 2012 she was admitted to the Hospital with a fracture of her left neck of femur following a fall. When she was admitted to the Hospital, healthcare professionals recorded on admission that she had cognitive impairment. Mrs A's husband (Mr A) held welfare and financial power of attorney. Healthcare professionals noted that one of Mrs A's daughters was the first (next of kin) point of contact and that Mrs C was the second. A do not attempt cardiopulmonary resuscitation (DNACPR) certificate was completed that day and the decision was discussed with Mr A. Mr A also consented to Mrs A undergoing an operation that day (an Austen Moore hemi-arthroplasty - the placement of a metal component at the top end of the femur). Following the operation, a consultant assessed Mrs A (on 21 November 2012) and said she should return to the care home when it was safe to do so following rehabilitation. It was recorded in the clinical notes that Mrs A had three falls on 28 November 2012. Mrs A was discharged to the care home on 4 December 2012. Several days later (on 6 December 2012), Mrs A was re-admitted to the Hospital following reports of hip pain. A discharge planning meeting took place on 12 December 2012. On 17 December 2012, it was documented in Mrs A's clinical notes that she fell twice before she was discharged to the care home that day.

Relevant legislation

8. The Adults with Incapacity (Scotland) Act 2000 (the Act) provides a framework for safeguarding the welfare and managing the finances of adults who lack capacity due to mental disorder or an inability to communicate. The Act allows treatment to be given to safeguard or promote the physical or mental health of an adult who is unable to consent. The Act is underpinned by a set of principles founded in human rights legislation. The principles apply to medical treatment decisions as to other areas of decision-making. Where a welfare attorney or guardian has been appointed with health care decision-making powers the doctor must always seek his or her consent where it is practicable and reasonable to do so. Where a patient has not appointed an attorney or

guardian, medical treatment may still be provided without consent if a certificate of incapacity with a specified validity period is issued (called a section 47 certificate). The professional carrying out an assessment of capacity must determine if the person's preserved intellectual and information-processing abilities are sufficient to support reasoned decision-making with respect of their current situation and consult with relevant others whenever practicable and reasonable.

Relevant Board policy

9. The Board's joint discharge planning guidelines (with the local authority) include a number of standards related to multi-disciplinary team working and discharge planning including:

'a. the requirement for the multidisciplinary team to meet at least weekly;
b. the requirement to identify an expected discharge date within 24 hours of admission;
c. the need for effective communication within the multidisciplinary team meeting;
d. the need to ensure effective communication with relatives/carer;
e. the requirement to complete an agreed template for each patient at each multidisciplinary team meeting;
f. the requirement to assess patients' pharmaceutical care needs within two days of admission;
g. the requirement to complete an immediate discharge letter; and
h. the requirement to complete a discharge checklist as part of the planning process.'

(a) The Board failed to provide a reasonable standard of nursing care and treatment to Mrs A

10. Mrs C complained about Mrs A's discharges from the Hospital saying that communication between the care team and the family and within the care team itself was unacceptable and that Mrs A was unreasonably discharged because she resided in a care home. In relation to the discharge of 4 December 2012, Mrs C said it was disorganised and centred upon the Hospital's needs, rather than Mrs A's needs. Mrs C also said Mrs A was in great pain when she was discharged and that she did not receive her medication, adequate analgesia or nutrition for a significant period of time before leaving the ward, and that generally Mrs A was not helped properly to eat and drink. Mrs C further complained about the attempted discharge of Mrs A to a community hospital, which she said was unnecessary and not in Mrs A's best interests. She said the

healthcare professional's discussion with her father, Mrs A's appointed welfare attorney, about the matter had caused him a great deal of distress. In relation to the second discharge, Mrs C said that no medication was administered or nutrition provided to Mrs A for several hours before her departure from the ward. Finally, Mrs C complained about the number of post-operative falls Mrs A sustained while in the Hospital and said that some of the measures taken to minimise the risks were inappropriate. For example, Mrs C said a male nurse constantly stared at Mrs A for a period of time which caused her distress and it was inappropriate to leave Mrs A with a nurse call-buzzer given that she did not have the capacity to understand how to use it. Mrs C believed that staff were not trained to deal with patients with cognitive impairment and that such patients were discriminated against because of their condition.

The Board's response

11. The Board clarified that they did not have an early discharge policy for people who resided in care homes. However, on reviewing the discharge process in Mrs A's case, the Board accepted that the process would have benefited from a single individual overseeing the discharge process and so this would be reviewed and improvements made to ensure that communication was better coordinated in the future. The Board also apologised that the proposed discharge to a community hospital was discussed with Mr A and caused him distress when it was clear from the records that the first and second point of contact should have been Mrs A's daughters. They apologised that staff had not anticipated that the ambulance journey could have been uncomfortable and that they failed to provide Mrs A with pain relief before discharge.

12. In relation to falls, the Board said that Mrs A received a full Cannard score risk assessment during both admissions to the Hospital. Throughout these admissions, Mrs A was assessed on a routine basis as there were times she was clearly anxious and attempting to get on her own feet. Healthcare professionals attempted to reduce the risk of Mrs A falling by providing one-to-one nursing support when possible with increased observation. The Board apologised that she was agitated by the close monitoring of a nurse to reduce the risk of a fall taking place. The Board also explained that a jug of water had been removed to reduce falls risk and said that in situations like Mrs A's where high levels of observations were required, the aim was to provide one-to-one support but unfortunately due to high levels of activity in the ward it was not possible to provide this at all times during her admissions to the Hospital. However, drinks were offered to Mrs A on a regular basis under supervision.

The Board explained there was no discrimination in terms of the care Mrs A received and there were safeguards in place to ensure health boards did not discriminate against patients because of their dementia. However, they acknowledged that there were areas of care that could have been better and these would be addressed with the staff concerned.

Advice obtained

13. The Nursing Adviser said it was clear from the evidence in the clinical records that Mrs A lacked capacity to make informed decisions about care and treatment when she was admitted to the Hospital on 20 November 2012. It was also clear that healthcare professionals were aware of her incapacity from the outset and that the operation and DNACPR decision was fully discussed with Mr A, who agreed that they could contact his daughter about treatment and consent. However, healthcare professionals should then have completed a section 47 certificate and filed this in Mrs A's clinical notes. The code of practice to the relevant legislation also recommended the use of treatment plans, which should be attached to the certificate in situations such as Mrs A's where 'multiple complex health care interventions' were anticipated. There was no evidence of a care plan of this nature in Mrs A's clinical records. While the DNACPR certificate was completed appropriately and in line with the relevant policy[1], in relation to on-going care and discharge planning, communication with the family appeared to have been arbitrary rather than a strategic, premeditated aspect of Mrs A's care plan.

14. My complaints reviewer asked the Nursing Adviser if the care and treatment provided to Mrs A in relation to falls prevention was reasonable. The Adviser said there was no evidence in Mrs A's clinical records indicating that falls assessments were carried out at any point during her first admission even though the Board had referred to a Cannard score in their response to the complaint. When my complaints reviewer asked the Board about this, the Board provided a copy of a completed Canard falls risk assessment (for 21 November 2012 and 6 December 2012) for an unnamed patient saying that this document was included in Mrs A's patient notes. However, the Nursing Adviser (and the complaints reviewer) could not find a copy of this document in the copy of Mrs A's clinical records that the Board had provided. Nor was there any evidence of a care plan even though Mrs A was admitted with a hip fracture following a fall and was assessed initially as being confused and very unsafe

[1] NHS Scotland (2010): Do Not Attempt Cardiopulmonary Resuscitation

when mobilising. Furthermore, the three recorded falls in one day (28 November 2012) appeared not to have prompted healthcare professionals to complete a falls assessment, and there was no evidence that healthcare professionals attempted to determine her falls history before the fall which necessitated her first admission.

15. The Nursing Adviser went on to say that while the medical notes recorded that three falls took place on 28 November 2012, the nursing notes were silent in relation to the first two (un-witnessed) falls and there was no evidence to support the completion of incident reports for any of the falls which occurred that day in the copy of Mrs A's clinical records that the Board had provided. However, the Board provided a copy of an incident report relating to Mrs A's third fall that day in response to enquiries from my complaints reviewer. In relation to Mrs A's second admission (from 6 December 2012 until 17 December 2012), the Nursing Adviser could find no evidence of completed Canard falls assessments even though two Cannard scores were recorded in part of the clinical notes. (The dates on the unnamed patient documentation provided later by the Board were not consistent with the dated Canard scores identified by the Nursing Adviser.) Furthermore, there was no evidence of an incident report being completed for the two falls that occurred on 17 December 2012. The Nursing Adviser further added that it appeared the falls did not prompt a Canard assessment review (contrary to the Board's policy on falls) which could have informed care planning when Mrs A was discharged to the care home and that only one of these falls was mentioned in the nursing transfer summary document.

16. In relation to measures to minimise the risks of falls, the Board said that Mrs A required a higher level of observation. However, the Nursing Adviser found no evidence in the clinical notes for either admission which specified the level of observation required and how this was to be carried out or kept under review even though there were a number of entries in the notes about Mrs A's compromised safety because of her impaired mobility. The Board told Mrs C in the response to the complaint that where high levels of observation were required, they aimed to provide one-to-one support whenever practicable but due to high levels of activity, it was not always necessary to provide this level of support all of the time. However, the Nursing Adviser said that if a patient required an enhanced level of observation to maintain safety, then it should be provided or an alternative means of maintaining a safe environment should be identified. These measures should be explicitly recorded in the care plan and

there were many ways in addition to direct one-to-one engagement of minimising the risk of a fall. There was no evidence in Mrs A's records of a coherent falls prevention care plan incorporating such measures. In relation to whether Mrs A was provided with a nurse call buzzer, there was no reference to this in her clinical notes. However, if it had been done to minimise Mrs A's falls risk it would have been ineffective as this was not an appropriate safety measure for people with significant cognitive impairment. The Nursing Adviser concluded that the evidence from the clinical records indicated a disorganised approach to falls assessment and care planning and that practice fell below an acceptable standard. Record-keeping and an incident reporting of falls events was also unreasonable.

17. Turning now to Mrs A's discharges on 4 and 17 December 2012, the Nursing Adviser said that effective multi-disciplinary working and communication was integral to coherent and systematic discharge planning. In relation to Mrs A's discharge on 4 December 2012, the Nursing Adviser said it was clearly recorded in her clinical notes that the care home would not accept her return without a clear discharge plan being in place. The care home also requested that a discharge meeting be convened and it was recorded (on 30 November) that the care home were unhappy with the level of communication with the relevant health care professionals. In line with the policy, the Nursing Adviser said should there have been at least two multi-disciplinary discharge planning meetings during Mrs A's first admission to hospital but there was no evidence that these took place. At one point, discharge to a community hospital was considered, but this went no further when a psychiatric liaison nurse said it would have significantly impeded Mr A's ability to visit his wife. The Nursing Adviser said the fact that this community hospital was considered was indicative of a failure on part of the clinical team to take account of Mrs A's psychological and social care needs. While there were a number of different healthcare professionals involved in planning matters related to the first discharge including communicating with the care home, the Nursing Adviser said no one appeared to have taken over the responsibility for ensuring a coherent coordinated planning approach which should have included the convening and chairing the discharge planning meetings and ensuring effective communication with the family. It was the Nursing Adviser's view that this strongly suggested an ineffective clinical leadership at ward level. Communication within the multi-disciplinary team itself and with the care home and the family was disorganised and inefficient, and led to confusion, false

impressions and misapprehensions. Also, there was no evidence that Mrs A's pharmaceutical needs were assessed contrary to the policy.

18. In relation to the second discharge (of 17 December 2012), a discharge planning meeting took place on 12 December 2012 but the Nursing Adviser expected at least one other discharge planning meeting in line with the policy. The last of these meetings should have finalised and explicitly recorded the discharge plan. The Board's own multi-disciplinary meeting template was not used to record the meeting and subsequently some details that should have been recorded have been missed, for example, expected date of discharge, the person with responsibility for communicating with relatives etc. An audit tool (to be completed at the point of discharge) was not used and the Nursing Adviser said that an opportunity to gather important information was missed. As in the first discharge, the Nursing Adviser said that communication with relatives appeared to have been at their behest or opportunistic rather than part of a planned communication process. Furthermore, there was little evidence that the family was involved in the decision-making process as they should have been. Having said that, a detailed nursing transfer summary document was completed on the day of discharge which would have provided essential information to the care home in relation to Mrs A's immediate care needs although there was no evidence of similar documents completed when Mrs A was discharged on 4 December 2012. The Board also acknowledged that Mrs A did not receive pain relief for 24 hours before her discharge. The Nursing Adviser said while it was clear that she refused her medication on the morning of discharge, it was not clear why it was not administered at other times when it was due before she left in the early evening, which was concerning.

19. The Nursing Adviser identified further failings that were concerning in relation to nutrition and pain assessment. Turning first to nutrition, Mrs A had diabetes that was diet controlled and so an appropriate diet and monitoring of her nutritional intake were important aspects of clinical care. Notwithstanding Mrs A's diabetes, the Nursing Adviser said the malnutrition universal screening tool (MUST) should be completed for all hospital in-patients, but there were no assessments evident in the clinical notes. During Mrs A's second admission, healthcare professionals recorded that no MUST assessment was completed during her previous admission but then failed to complete one for the second admission. Moreover, despite it being recorded on a number of occasions that Mrs A's fluid and dietary intake was poor, there was no evidence that her dietary intake was charted and there was only a single entry related to food intake and

the monitoring charts. Furthermore, there was no nutritional care plan. The Nursing Adviser noted that while Mrs A's water jug was removed to prevent her spilling it and slipping - which was reasonable - there was no evidence that her fluid intake was monitored which meant that healthcare professionals could not ensure adequate fluid intake. The Nursing Adviser concluded that Mrs A's fluid and nutritional care was not individualised and fell far below the standard set out in national guidance[2].

20. Turning now to pain assessment, the Nursing Adviser said that unfortunately the under detection of pain was not uncommon in the care of older people with cognitive impairment. It was important to recognise the significance of pain in people who were unable to effectively express their needs; pain affected mood and functioning in all patients and these effects were particularly undesirable for patients with cognitive impairment because disordered sleep and mood could adversely affect cognition. Pain was also linked to behavioural abnormalities in those with dementia. It was, therefore, very important to recognise and assess the extent and impact of pain in this patient group. Pain could be difficult to assess in cognitively impaired people because self-reports of pain could be inaccurate and difficult to obtain. An observational pain assessment tool should be used to gauge the nature and level of pain being experienced by a person who was unable to verbalise their pain experience[3]. Mrs A's cognitive impairment, particularly her receptive and expressive dysphasia placed her in this category. The monitoring charts from the clinical records indicated that her pain was being monitored but it appeared that the monitoring was reliant upon her being able to respond effectively to questions about pain and/or random observation. There was no evidence of an observational pain assessment tool used contrary to national guidelines[4]. The Nursing Adviser concluded that given Mrs A had a significant degree of cognitive impairment including receptive and expressive dysphasia, her pain was unreliably assessed and monitored.

21. My complaints reviewer asked the Nursing Adviser about Mrs C's concern that nursing staff failed to provide Mrs A with a reasonable standard of care and treatment because of her cognitive impairment. The Nursing Adviser said that there were a number of significant shortcomings in relation to the planning and

[2] NHS Quality Improvement Scotland (2003): Fluid, Food and Additional Care in Hospital
[3] International Journal of Palliative Nursing (2004): The Abbey Pain Scale
[4] Royal College of Physicians et al (2007): The Assessment of Pain in Older People, National Guideline No 8

delivery of Mrs A's care and overall treatment. Her needs arising from her cognitive impairment were ineffectively assessed. There was a lack of evidence of person centred care planning (as required by the national dementia standards[5]) and her nutritional needs were not assessed. Healthcare professionals failed to utilise a specialist pain assessment tool for the cognitively impaired to assess her pain and her communication needs were not assessed (beyond stating that she needed glasses). Assessment was also silent in relation to needs arising from confusion, understanding, comprehension and her expressive dysphasia. There was no evidence of a care plan which addressed how her needs related to the maintenance of a safe environment, confusion, anxiety, communication, comprehension and pain and urinary incontinence were to be managed. The Mental Welfare Commission emphasised the importance of healthcare professionals in general wards seeking specialist psychiatric advice to support them in appropriately meeting the needs of people who were cognitively impaired. There was no evidence in the clinical records that specialist advice been sought to inform the development of the care plan to meet the dementia associated needs of Mrs A. However, there was no evidence that the failings, which the Nursing Adviser said were alarming, arose because of Mrs A's cognitive impairment. Having said that, it was the Nursing Adviser's view that failure to follow national guidance and Board policy meant that Mrs A's rights as an NHS patient and as a person with dementia were infringed. They said that care seemed to have been poorly led and coordinated and the overall sense was one of the lack of organisation, ineffective team working, inadequate communication and failure to follow due process.

(a) Decision

22. Mrs C complained that the Board failed to provide a reasonable standard of nursing care and treatment to Mrs A. In reaching my decision, I have taken into account Mrs A's clinical records and the advice I have received. The Nursing Adviser said that Mrs A's care was ineffectively planned and implemented, that Mrs A's needs were not adequately assessed and, in particular, a lack of regard was given to the care needs she had which arose from her diagnosis of dementia. The Nursing Adviser also highlighted record-keeping failures on a wide range of areas including: assessment of dementia associated needs; personalised care planning; psychological care; falls prevention; incident reporting; fluid balance; nutritional care; and discharge

[5] Scottish Government (2011): Standards of Care for Dementia in Scotland

planning. I accept that advice. It is also clear to me that these failings were exacerbated by significant shortcomings in communication. In relation to falls prevention, I am particularly concerned about healthcare professionals' failure to take appropriate cognisance of Mrs A's cognitive impairment in a falls risk context. Mrs A was admitted initially to hospital because of a fracture arising from a fall, and yet sustained a total of five falls during her admissions to hospital. While I accept it was not possible to eliminate the risks of falling altogether, reasonable and appropriate falls management would have minimised the risks.

23. Clearly, Mrs C has been extremely distressed by what happened and raised concerns with me that Mrs A was treated unfavourably by healthcare professionals because of her cognitive impairment. While I did not find any evidence showing this, it is evident to me that she was disadvantaged because of the extensive failings I identified, and I am concerned that the Board's practices (at the Hospital) may be failing to meet the needs of patients with cognitive impairment generally. Given the vulnerability of this group of patients, this is very troubling and needs to be addressed urgently. I uphold the complaint and I make a number of recommendations to address the failures identified. I have also made general recommendations at the end of this report that not only address some of the failures identified here, but also those under complaints (b) and (c).

(a) Recommendations

24. I recommend that the Board:	*Completion date*
(i) monitor practice to ensure national dementia standards are being met including specifically that the presence of cognitive impairment is given due regard in the planning of care, and that the level of observation, supervision and provision of support provided to people with delirium and/or dementia is appropriate for their impaired capacity;	20 June 2015
(ii) ensure that staff comply with adults with incapacity legislation, in particular completing section 47 certificates and accompanying care plans;	20 June 2015
(iii) take steps to ensure communication with relatives and carers of patients with cognitive impairment is proactive and systematic;	20 June 2015

(iv)	ensure that falls prevention clinical practice is administered within the Hospital in line with recognised good practice and Board policy;	20 June 2015
(v)	ensure that nutritional care is carried out in line with national policy and that nutritional care plans are developed, implemented and evaluated for each patient as appropriate;	20 June 2015
(vi)	explore all options to implement an observational pain assessment tool for use with patients with cognitive impairment; and	20 June 2015
(vii)	undertake an audit of record-keeping in wards caring for patients with cognitive impairment to ensure compliance with record-keeping guidelines and a reasonable standard of practice.	20 July 2015

(b) The Board failed to provide a reasonable standard of medical care and treatment to Mrs A

25. Mrs C complained about the standard of medical care and treatment provided in relation to pain relief and communication, particularly around discharge. Mrs C was also concerned that the Board told her that medical staff would not normally follow-up hip surgery with out-patient appointments for patients with dementia who reside in care homes.

The Board's response

26. The Board said Mrs A made a good post-operative recovery from her operation on 20 November 2012. The following day, Mrs A started her rehabilitation programme and she was assessed by the Consultant. The consultant recommended that Mrs A should return to the care home when her rehabilitation and mobilisation was at a stage that would allow this to happen safely. Finally, the Board said that follow-up appointments were not routinely given to patients discharged after a fractured neck of femur.

Advice obtained

27. The Medical Adviser agreed with the Nursing Adviser that there were a number of failings in caring for Mrs A as a patient with cognitive impairment. They said that it was a major failing that the consent process for Mrs A's care did not include documenting the safeguards of the relevant legislation (see paragraph 8). However, in relation to Mrs A's DNACPR status, the Medical Adviser said there was evidence medical staff recognised the powers held by

Mrs A's family and that the family was included in discussions about the operation and agreed that it was in Mrs A's best interests at the time. While the Medical Adviser said that the failures were in relation to documentation rather than care, the safeguards of the relevant legislation should have been used as well as the ones for the DNACPR were.

28. My complaints reviewer asked the Medical Adviser if the provision of analgesia to Mrs A during both admissions to hospital and on discharge was reasonable. The Medical Adviser explained that while there was no evidence that Mrs A's pain relief was inadequate around the time of her operation, they were critical about what happened when she was discharged. Mrs A's immediate discharge summary for 17 December 2012 included a medication list for her to take after discharge which suggested that she should take regular analgesia (paracetamol) four times a day. This was also the case for her discharge on 4 December 2012 and reflected the dosage of paracetamol she was taking when she was admitted. However, the prescription record showed that she did not have paracetamol (or codeine, the other painkiller she was prescribed) the night before discharge (as she was sleeping) nor the first planned dose in the morning of 4 December 2012. The Medical Adviser agreed that the journey after discharge was very uncomfortable particularly given the recent trauma and surgery that Mrs A had sustained and that the failure to provide analgesia was unreasonable.

29. In relation to communication, the Medical Adviser said unlike discussions about Mrs A's DNACPR status when she was admitted, there was little documented communication between medical staff and her family after her operation on 20 November 2012. For example, in relation to Mrs A's admission on 17 December 2012, there were very few medical entries, and those were generally reactive in response to events such as a fall. There was no documentation of any discussions about conditional discharge between medical staff and her family. There was only one entry from a geriatrician on 21 November 2012, but no subsequent review by them despite the length of Mrs A's admission exceeding their estimate that she may be able to be discharged on 26 November 2012. Likewise, in relation to Mrs A's operation during the admission on 4 December 2012, the medical entries by medical staff related to management of intercurrent health problems (a health condition that occurs during the course of another condition with which it has no connection) but there was no consideration of her discharge needs or any evidence of planning in this regard. The Medical Adviser was critical of the lack of input

from medical staff into Mrs A's care during both hospital admissions. There was little evidence of how much work medical staff were doing to help, particularly her consultants. The Medical Adviser would expect to find consultant entries detailing her progress and subsequent discharge plans at least twice a week, but this was not the case for Mrs A. The Medical Adviser was also critical that staff were not involved as they should have been in the discharge planning process and that they did not participate in the discharge planning meeting of 12 December 2012. The Medical Adviser was critical of these failings and said that her care fell below a reasonable standard.

30. Finally, the Medical Adviser said the Board's position that follow-up appointments were not routinely given to patients discharged after a fractured neck of femur was reasonable and in line with relevant guidelines[6].

31. The Medical Adviser concluded that while there was no direct evidence from the clinical records to suggest that Mrs A received less attention from medical staff because of her cognitive impairment, there was an overall sense of lack of care and attention to Mrs A from medical staff and that they failed to consider properly her cognitive impairment and the relevant legislation, which should have informed the process.

(b) Decision

32. Mrs C complained that the Board failed to provide a reasonable standard of medical care and treatment to Mrs A. In reaching my decision, I have taken into account Mrs A's clinical records and the advice I have accepted. The Medical Adviser said that the care and treatment provided by medical staff to Mrs A in relation to full consideration of her cognitive impairment, pain relief, communication and discharge was not reasonable. The Medical Adviser agreed that while there was no direct evidence suggesting she received less attention from medical staff because her of cognitive impairment, medical staff failed to meet her needs as a patient with cognitive impairment and be informed by the relevant legislation. While I accept the advice that it was reasonable for the Board not to offer a follow-up appointment when Mrs A was discharged, on the basis of the failures identified, I uphold the complaint. Some of the recommendations I made under complaint (a) in relation to communication and relevant legislation will address the related failures found here, and the

[6] Scottish intercollegiate guidelines network (111): Management of Hip Fracture in Older People

additional general recommendations at the end of the report address the other failures.

(c) The Board failed to provide a reasonable standard of physiotherapy and occupational therapy care and treatment to Mrs A

33. Mrs C complained about the lack of physiotherapy and occupational therapy input and said that no attempts were made by healthcare professionals to get Mrs A back on her feet before her discharge and that she should have had access to occupational therapy. She said that had Mrs A not suffered from dementia she would not have been discharged until she had regained some of her mobility.

The Board's response

34. The Board said that support was provided to promote Mrs A's mobilisation and that physiotherapy was provided on seven occasions during her admissions which include mobility assessments that recommended walking and standing aids. The Board apologised if it was not communicated clearly that patients with Mrs A's injury do not always get back to the previous level of functioning and that rehabilitating patients with dementia was often complex. The Board confirmed that a senior physiotherapist had told Mrs C that the provision of an available physiotherapy in care homes was inconsistent across the region, but stressed that Mrs A's diagnosis of dementia would have no impact on the level of physiotherapy service she could access. The Board also noted that the physiotherapist had referred Mrs A to one of her colleagues who had specific skills in working with patients with cognitive impairment. Mrs A subsequently received physiotherapy treatment from this physiotherapist when she was on the ward and later when she was discharged to the care home.

35. In relation to access to occupational therapy, the Board said those who had experienced a marked deterioration in functioning or those who live alone and were considered to be vulnerable were usually eligible for occupational therapy input. Because Mrs A was resident in a care home and had 24 hour care available she would not have met these criteria for an occupational therapy assessment and her diagnosis of dementia would not have been a barrier to her receiving occupational therapy. However, the care home requested an assessment and one was undertaken on 3 December 2012. There was a separate social work process for making referrals to community occupational therapy services for care home residents which should have been followed.

The Board acknowledged this had not been well communicated to relevant care home staff and said they would rectify the situation in the future.

Advice obtained

36. The Nursing Adviser (who confirmed they were in a position to comment on these issues) said the evidence from the clinical records indicated that Mrs A had regular daily physiotherapy input during her first hospital admission, which was focused on enhancing her mobility and recovery. It was clear that her cognitive impairment frequently made achieving physiotherapy goals difficult. There was also input before discharge from a physiotherapist with experience in the care of older people with cognitive impairment. Physiotherapy assessments and interventions had been clearly recorded. The Nursing Adviser concluded that the nature and frequency of the provision of physiotherapy, and physiotherapy record-keeping, during Mrs A's first admission to hospital was reasonable.

37. Turning now to occupational therapy, the Nursing Adviser said there was confusion about whether an occupational therapy assessment was required before Mrs A was discharged on 4 December 2012. While the Board said that Mrs A did not meet the criteria for an occupational therapy assessment, it was clear that Mrs A's family were told that an assessment was required, but had been overlooked. The Nursing Adviser could, therefore, appreciate the family's concerns that an assessment had not been carried out earlier as part of the discharge planning process. It was the Nursing Adviser's view that the assessment appeared to have been done late in the process (the day before discharge) because healthcare professionals were prompted to do so by care home staff. The Nursing Adviser said the confusion appeared to have arisen because of ineffective communication within the clinical team, lack of effective care planning and discharge planning and lack of clarity in relation to Board policy.

(c) Decision

38. Mrs C complained that the Board failed to provide a reasonable standard of physiotherapy and occupational therapy care and treatment to Mrs A. In reaching my decision, I have carefully considered Mrs C's account of what happened and Mrs A's clinical records. Clearly, Mrs C feels strongly that healthcare professionals should have attempted to mobilise Mrs A before her discharge and that she should have had access to occupational therapy. However, the advice I have accepted is that Mrs A received a reasonable

standard of physiotherapy treatment. Having said that, the Nursing Adviser also noted that there was confusion on whether an occupational therapy assessment was required before discharge. The Board have acknowledged and apologised for their failure to follow the process for referrals to community occupational therapy services for care home residents. While I appreciate that this caused additional uncertainty and upset to Mrs C, I am satisfied that on the whole the provision of physiotherapy and occupational therapy was reasonable. On balance, therefore, I do not uphold the complaint. However, general recommendation (i) below will address the shortcoming.

General Recommendations

39. I recommend that the Board:	*Completion date*
(i) review their discharge policy to ensure: its continued relevance in light of the failings arising from this case; it meets the needs of people with cognitive impairment and the need to fully involve the family in decision-making; a more systematic approach to discharge planning; and pre-discharge assessments are clearly identified at an early stage and carried out within a reasonable time to inform follow-up care;	20 July 2015
(ii) ensure the failures identified are raised as part of the annual appraisal process of relevant staff and address any training needs particularly in relation to falls prevention and adults with incapacity legislation; and	20 June 2015
(iii) apologise to Mrs C for the failures this investigation identified.	20 June 2015

40. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs A	the complainant's mother
Mrs C	the complainant
the Hospital	Borders General Hospital
the Board	Borders NHS Board
the Nursing Adviser	one of the Ombudsman's advisers who specialises in mental health
the Medical Adviser	one of the Ombudsman's advisers who specialises in care of the elderly
Mr A	the complainant's father
DNACPR	do not attempt cardiopulmonary resuscitation
the Act	Scottish Public Services Ombudsman Act 2002
MUST	malnutrition universal screening tool
the Consultant	a consultant in care of the elderly at the Hospital

Annex 2

Glossary of terms

dysphasia	partial or complete impairment of the ability to communicate
femur	thigh bone
an Austen Moore hemi-arthroplasty	the placement of a metal component at the top end of the femur

Annex 3

List of legislation and policies considered

Adults with Incapacity (Scotland) Act 2000

The Board's joint discharge planning guidelines (with the local authority)

NHS Scotland (2010): Do Not Attempt Cardiopulmonary Resuscitation

NHS Quality Improvement Scotland (2003): Fluid, Food and Additional Care in Hospital

International Journal of Palliative Nursing (2004): The Abbey Pain Scale

Royal College of Physicians et al (2007): The Assessment of Pain in Older People, National Guideline No 8

Scottish Government (2011): Standards of Care for Dementia in Scotland

Scottish Intercollegiate Guidelines Network (111): Management of Hip Fracture in Older People