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: Mid Scotland and Fife

Case ref: 201507500, Fife NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mrs C complained about the care and treatment her husband (Mr C) received at the Victoria Hospital, Kirkcaldy.

Mrs C said that her husband suffered a fall getting out of bed while on holiday abroad which had caused him to hit his head and lose consciousness for approximately ten minutes. On arrival home a few days later, Mr C attended the hospital's emergency department. He was treated as a minor head injury and discharged home the same day with head injury advice. Mrs C complained that Mr C was not provided with appropriate treatment, and, in particular, that a CT scan was not carried out.

Eleven days later, Mr C returned to the hospital as he had a constant headache. Mrs C said that, although on this occasion a CT scan was carried out, she had to beg staff to carry it out. The scan showed Mr C had suffered a brain haemorrhage. He was transferred the same day to another hospital where he had a craniotomy for an acute subdural haematoma.

Mr C was subsequently transferred back to the Victoria hospital and admitted to a ward. Mrs C was unhappy with the nursing care Mr C received there.

During our investigation we took independent advice from three advisers: a consultant in emergency medicine, a consultant neurosurgeon and a nurse. We found that given his presenting symptoms, an urgent CT scan of Mr C's head should have been carried out when he first presented to the emergency department, and the decision not to do was a significant and serious failing. We also found that the failure to carry out a CT scan had delayed Mr C's diagnosis and treatment and adversely affected his outcome. If the diagnosis and treatment had been made sooner there would in all probability have been a significantly improved prognosis for Mr C. Given this we upheld this aspect of Mrs C's complaint.

We considered, however, that the treatment Mr C received when he returned to the emergency department was timely and was of an excellent standard. Therefore, we did not uphold this part of Mrs C's complaint.

In relation to the nursing care which Mr C received, the board said they had identified a number of issues where Mr C's care and their communication with Mrs C had at times fallen short of the standard Mrs C expected and they had apologised. The board said these matters were also addressed with the nursing staff concerned. We received advice that Mr C's brain injury had caused him to exhibit behaviour which was at times difficult for staff to manage. While there were many aspects of Mr C's nursing care which were reasonable, we found that he should have been observed for falls better. We also identified shortcomings in how Mr C's nursing records were kept. We considered that, on balance, and in the circumstances of this case, the nursing care provided to Mr C was not reasonable and we therefore upheld this aspect of Mrs C's complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mr C and Mrs C:

Complaint number	**What we found**	**What the organisation should do**	**Evidence SPSO needs to check that this has happened and the deadline**
(a)	The Victoria Hospital's Emergency Department failed to carry out a CT scan of Mr C's head when he attended on 22 August 2015	Provide a written apology for the failure, that complies with the SPSO guideline on making an apology (available at https://www.spso.org.uk/leaflets-and-guidance)	Copy of the apology letter By: 19 August 2017

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Victoria Hospital's Emergency Department failed to carry out a CT scan of Mr C's head when he attended on 22 August 2015	The Board should reflect and learn from the comments of Adviser 1 and Adviser 2 for the management of patients with a head injury. This review should consider how learning from the specific incidents of this case, in particular, where patients present with a sudden onset of severe headache (whether following a head injury or spontaneously). The review should be used to inform the need for systemic improvement in this aspect of the Board's service	Documentary evidence that reflection has taken place and learning captured, such as copies of minutes of discussions of this report with the relevant staff and managers, internal memos/emails, or reports, and documentation showing feedback given By: 19 September 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Victoria Hospital's Emergency Department failed to carry out a CT scan of Mr C's head when he attended there on 22 August 2015	The Board should demonstrate they have acted on their learning to ensure their procedure for the management of patients with a head injury, in particular, where patients present with a sudden onset of severe headache. (whether following a head injury or spontaneously) are fit for purpose and reduce the likelihood of a recurrence of the circumstances of this case	Documentary evidence of procedural review and subsequent change. This should include revised procedures with changes highlighted. It could include: copies of process audits, internal meeting minutes, review reports or a detailed explanation of the review and its conclusions / any resulting process changes By: 19 September 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(c)	Nursing staff caring for patients who have suffered a brain injury and for patients with challenging behaviour were not sufficiently well trained	The Board should ensure nursing staff caring for patients who have suffered a brain injury, and for patients with challenging behaviour, receive appropriate learning and development and that mechanisms exist to ensure this is kept up-to-date	Documentary evidence that these training needs are being met, or planned (with definitive timescales, not simply a broad intention) By: 19 September 2017
(c)	There were omissions in record-keeping in relation to the assessment of capacity and consent/violence and aggression assessment	The Board should ensure that systems are in place that ensure nursing records are maintained in accordance with the nursing and midwifery code of practice	Documentary evidence such as discussions about this report, changes that are (or have been) made as a result, and revised procedures or instructions to staff about the application of current procedures By: 19 September 2017

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(a)	The Board acknowledged that Mr C's care had at times fallen short of the standard Mrs C would expect	The Board said Mrs C's concerns had been shared with the nursing staff and staff had been asked to reflect on this and consider how Mr C's care could have been better	Documentary evidence of discussion of Mrs C's concerns with the relevant nursing staff at a staff meeting By: 19 September 2017

Feedback for Fife NHS Board

Complaint Number (c)

Points to note: Given the comments of Adviser 3, the Ombudsman recommends the Board give consideration to having a dedicated ward/part of a ward where patients who have suffered a brain injury and/or exhibit challenging behaviour can be cared for jointly by acute and mental health teams with appropriate staffing levels.

When responding to a draft of this report, the Board told me that, having considered it, it would not be practicably possible to deliver the point noted in my feedback. Even so, they will make every effort to accommodate patients with this presentation within two specific wards of Hospital 1 where they have an acute psychiatric liaison service/unscheduled care team. The Board have also informed me that the supervision procedure for patients requiring one-to-one intensive supervision is currently under review. It is ultimately a matter for the Board, and I am pleased that they considered the feedback in relation to their services, seriously.

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, and her husband is referred to as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to my office about the care and treatment her husband (Mr C) received at the Victoria Hospital, Kirkcaldy (Hospital 1).

2. Mrs C said Mr C suffered a fall getting out of bed while on holiday abroad in August 2015. Mrs C said the fall had caused Mr C to hit his head and lose consciousness for approximately ten minutes. On arrival home a few days later, as Mr C 'was not himself', he attended Hospital 1's Emergency Department (ED) on 22 August 2015. Mrs C said Mr C was treated as a minor head injury and was discharged home the same day with head injury advice. Mrs C complains that the ED failed to provide Mr C with appropriate treatment; in particular, they failed to carry out a Computerised Tomography (CT) scan.

3. On 2 September 2015 Mr C returned to the ED as he was suffering with a constant headache. Mrs C said that, although on this occasion a CT scan was carried out, she had to 'beg' staff to carry it out. The CT scan showed Mr C had suffered a brain haemorrhage. Mr C was transferred the same day to Western General Hospital, Edinburgh (Hospital 2). On 3 September 2015, Mr C underwent a craniotomy for an acute subdural haematoma.

4. On 13 October 2015 Mr C was transferred back to Hospital 1 and admitted to Ward 42 (the Ward). Mrs C was unhappy with the nursing care Mr C received while he was a patient there.

5. Mrs C complained to Fife NHS Board (the Board). Mrs C met with the Board's Head of Nursing, ED Directorate, and their Patient Relations Team Coordinator. Mrs C was dissatisfied with the Board's response to the concerns she raised and complained to my office.

6. The complaints from Mrs C I have investigated are that:

(a) the Victoria Hospital's Emergency Department failed to take reasonable action when Mr C attended there in August 2015 (*upheld*);
(b) the Victoria Hospital's Emergency Department failed to take reasonable action when Mr C attended there in September 2015; (*not upheld*); and
(c) the nursing care provided to Mr C while he was in the Ward of Hospital 1 was unreasonable (*upheld*).

Investigation

7. My complaints reviewer examined all of the relevant documentation provided by Mrs C and the Board. This included Mr C's medical and nursing records and the Board's complaint file. They also obtained independent advice from three expert advisers: a consultant in emergency medicine (Adviser 1), a consultant neurosurgeon (Adviser 2) and a nurse (Adviser 3) on the clinical aspects of the complaint.

8. In this case, I have decided to issue a public report on Mrs C's complaint because of my concerns about the significant and serious failing identified in Mr C's care and treatment from when he presented to the ED on 22 August 2015 and because the failings I found have caused significant personal injustice to Mr C.

9. The nature of the complaint and the information seen means I cannot include 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.

Relevant guidelines

10. The Scottish Intercollegiate Guidelines Network publishes guidelines relevant to this complaint titled 'Early management of patients with a head injury' (the SIGN guidance). The SIGN guidance includes details of the Glasgow Coma Scale (GCS), which provides a framework for describing the conscious state of a patient in terms of three aspects of responsiveness: eye opening, verbal response and best motor response. A patient is scored in each of these areas, providing a useful single figure summary, ranging from 3 to 15, with 15 representing full consciousness. The SIGN guidance also provides criteria for brain CT scanning in head injured patients.

(a) Hospital 1's Emergency Department failed to take reasonable action when Mr C attended there in August 2015

Concerns raised by Mrs C

11. Mrs C said Mr C fell, while on holiday abroad, on 18 August 2015. She said he had hit his head on furniture and the floor, and was unconscious for ten minutes. Mrs C said Mr C 'was not himself' when he returned home on 21 August 2015, so he attended the ED on 22 August 2015. Mrs C accompanied Mr C to the ED.

12. Mrs C told us that despite Mr C complaining of headaches and being on blood thinning medication, a CT scan was not carried out. Mr C was told he was 'alright' and was discharged home with an advice leaflet and told to return to Hospital 1 if he had further headaches. Mrs C believes a CT scan should have been carried out when Mr C attended the ED on 22 August 2015.

13. Mrs C said it was only when Mr C re-attended the ED on 2 September 2015 and a CT scan was carried out that he was found to have suffered a brain haemorrhage. Mr C was transferred the same day to Hospital 2, where he required brain surgery, and he remained in the Critical Care Department for several weeks.

The Board's response

14. The Board said Mr C first presented to the ED on 22 August 2015 at 10:39. He was assessed by a triage nurse at 11:30 and seen by a junior clinical fellow (Doctor 1) at 13:35. Doctor 1 recorded in Mr C's medical records that he was complaining of a headache and while on holiday on 18 August 2015 he had fallen getting out of bed and hit his head on a table, chair and the floor. The Board said Mr C had advised Doctor 1 that he remembered falling and had no preceding symptoms. Doctor 1 also recorded that Mrs C had reported that Mr C had lost consciousness for five to ten minutes but he had not had a seizure and, although an ambulance was called, Mr C had not gone to hospital.

15. The Board said Mr C was assessed by Doctor 1. During this assessment, Mr C reported that he had suffered no vomiting, no neurological symptoms and no rhinorrhoea (runny nose). Mr C said he had a past medical history of two transient ischaemic attacks and his regular medications were clopidogrel and atorvastatin. Doctor 1 recorded that Mr C stated he had a mild headache intermittently since his fall but generally felt well. However, after picking up a bag of cement at 10:30 that morning his head was 'bursting' and he felt lightheaded and nauseated. When asked by Doctor 1, Mr C had rated this headache as having come on suddenly and was on a scale of nine out of ten. Mr C also said he had taken two paracetamol and had felt back to normal, aside from a one to two out of ten head pain which did not get worse when lying flat.

16. The Board said the examination of Mr C concluded that he had a GCS of 15 out of 15 with normal gait. The Board explained that the GCS is a system for assessing the severity of brain impairment in a person with brain injury which uses the sum of scores given for eye-opening, verbal and motor responses.

Mr C's pupils were equal and reactive to light and accommodation and he had a full range of eye movement. While it was recorded that Mr C had reduced vision in the lower quadrant of his right eye, Mr C had said this was due to a longstanding problem with a lazy eye he had since birth.

17. The Board said the examination of Mr C also concluded that his tone, power, reflexes and sensation were normal in all four limbs, there was no sign he had a skull fracture and no abnormalities were detected in his cervical spine. The Board said Doctor 1's impression was that Mr C had a sudden onset headache five days after sustaining a head injury, which was almost resolved. Mr C was given one gram of paracetamol orally at 13:55.

18. As Mr C was taking clopidogrel, Doctor 1 discussed his presentation with an ED medical registrar (Doctor 2). Doctor 2 reviewed Mr C and it was agreed that he did not require a CT scan. The Board said Doctors 1 and 2, in their assessment of Mr C, had referred to the SIGN guidance. It was documented that Mr C did not require a CT scan at that time and this was in accordance with the SIGN guidance.

19. The Board said that, given Mr C's symptoms, he was treated as having a minor head injury on this occasion. Mr C was discharged home at 14:15 with clear verbal and written advice to return immediately to the ED if any of his symptoms worsened; in particular, if he developed a severe headache not relieved with simple pain medication. The Board said the head injury advice leaflet given to Mr C included instructions to return immediately to the ED for reassessment to rule out serious brain injury if any of the following occurred: sudden severe headache not relieved with simple pain medication; appearing to be very confused or not making sense; difficulty in waking and keeping awake.

20. The Board, when responding to the complaint, stated that a consultant in the ED (Doctor 3) had investigated Mr C's care following the complaint from Mrs C. According to the Board, Doctor 3 had confirmed that the documented presentation of Mr C was consistent with him having sustained a minor head injury with mild symptoms of concussion (a mild headache, lightheaded, dizziness, memory problems, poor concentration, irritability, tiredness, nausea, poor sleep). The Board said the SIGN guidance advised that these symptoms were common and should resolve without any treatment, but if any of the symptoms persisted beyond two weeks the patient should seek a medical review.

21. The Board said Doctor 3 had subsequently discussed the results of the CT scan on 2 September 2015 with a consultant radiologist, who had stated that it was impossible to confirm how long the bleeding in Mr C's brain had been present or when it began. Doctor 3 had advised that if Mr C had returned to the ED sooner or when his symptoms worsened it was likely that he would have had a CT scan earlier. Doctor 3 had concluded that Mr C was treated appropriately during his attendance at the ED.

Medical advice - Adviser 1

22. Adviser 1 said the decision whether to CT scan patients with a delayed head injury presentation was a combination of what relevant guidance the SIGN guidance contained and the doctor's own clinical judgement: Adviser 1 said the SIGN guidance was used extensively to guide the early assessment and management of head injured patients in Scotland. Adviser 1 told my complaints reviewer there was a limitation to the SIGN guidance because it was predominantly aimed at helping clinicians to decide how to investigate and manage patients in the period immediately following their injury, that is, within 24 hours of the injury being sustained. Adviser 1 said the SIGN guidance mentions the increased chance of these types of patients having sustained a significant head injury. Mr C, however, had sustained his head injury several days prior to his attendance at the ED. Adviser 1 told my complaints reviewer that, unfortunately, there was no definitive guidance with regard to how to decide whether to scan patients with delayed head injury presentations.

23. Adviser 1 referred my complaints reviewer to section 4 of the SIGN guidance: 'Referral to the emergency department'; in particular, sub-section 4.2 'Indications for referral to hospital' which states that adult patients 'who have sustained a head injury and who re-present with ongoing or new symptoms (headache not relieved by simple analgesia, vomiting, seizure, drowsiness, limb weakness) should be referred to hospital'.

24. Adviser 1 also referred my complaints reviewer to section 6 of the SIGN guidance: 'Care in the emergency department'; in particular, sub-section 6.4: 'unexpected return to hospital', which states:

> 'people who return to hospital unexpectedly following a head injury may have significant morbidity. In a retrospective study of 606 patients re-attending a trauma unit after a minor injury, 53.3% of re-attenders had a CT scan. Intracranial abnormalities were found in 14.4% of re-attenders,

which equated to 27% of patients scanned at re-attendance. Five per cent of re-attenders required neurosurgical intervention. Management of patients who return to hospital unexpectedly following a head injury should be discussed with senior members of staff.'

25. Adviser 1 said, in addition, Mr C was taking clopidogrel, which affects the way that platelets in the blood clump together to stop bleeding. Adviser 1 said that patients on clopidogrel are, therefore, at an increased risk of bleeding inside the head following a head injury when compared to patients not taking this medication. Adviser 1 explained that while section 4. 4.2 of the SIGN guidance also states that adult patients who have sustained a mild head injury and are taking antiplatelet medication (for example aspirin, clopidogrel) should be considered for referral to hospital, it provided no definitive guidance as to how this should change a doctor's decision making with regard to the need for a CT scan.

26. Adviser 1 said Mr C presented to the ED at 10:39. Adviser 1 explained that patients who attend emergency departments are seen shortly after arrival by triage nurses, who decide how urgent the patient's presentation is and classify patients into five categories of urgency: one to five. Adviser 1 said it was unclear from the medical records what triage category was allocated to Mr C. Adviser 1 told my complaints reviewer that as Mr C had presented with a sudden onset severe headache, they would have expected him to have been triaged into a category which meant he would ideally be seen by a doctor within an hour. Adviser 1 noted that Mr C was seen by Doctor 1 three hours after he arrived. Adviser 1 said that in ideal circumstances this was not reasonable. If, however, the ED was very busy at the time and there were more seriously ill patients present then this was understandable and reasonable.

27. Adviser 1 noted that from the time of Mr C's initial vital signs observations, it appeared he was seen by a triage nurse at approximately 11:30 and Doctor 1 at 13:35. Adviser 1 said Mr C's vital signs (conscious level, blood pressure, heart rate, breathing rate, temperature and blood oxygen level) were measured four times during this time. Adviser 1 told my complaints reviewer that this was good practice.

28. Adviser 1 noted that Doctor 1 had recorded the circumstances of Mr C's injury, that he had been experiencing a 'mild headache on and off' and that Mr C had experienced a sudden onset severe headache that morning while

lifting a bag of cement. This was described as having a severity of nine out of ten and being associated with nausea. It was also recorded that Mr C said he 'felt [his] head was bursting' and 'now feels back to normal aside from [one to two out of ten] head pain'. Adviser 1 considered Doctor 1's recording of Mr C's medical history was comprehensive and of a high standard.

29. Adviser 1 said Doctor 1 had carried out an examination of Mr C which was normal except for a slightly raised blood pressure and he was noted to have an area of visual field loss in his right eye which was thought to be longstanding. Adviser 1 said they considered the examination carried out by Doctor 1 was comprehensive and of a high standard.

30. My complaints reviewer asked Adviser 1 whether a CT scan should have been carried out at this time. Adviser 1 noted that Doctor 1, a junior doctor, had asked Doctor 2 to review Mr C. Adviser 1 said Doctor 2 was a more senior doctor who was an experienced fifth year specialist trainee in emergency medicine and was within two years of qualification as a consultant. Adviser 1 said Doctor 2 made the decision that a CT scan of Mr C's head was not required. It appeared that Mr C was then discharged with written head injury warning advice, which Adviser 1 said was standard practice in all emergency departments and provides advice to patients and their families with regard to concerning symptoms to be aware of and what action to take.

31. Adviser 1 told my complaints reviewer that the SIGN guidance does not provide prescriptive guidance on whether or not to scan people who present some days after a head injury. It also provides no definite guidance with regard to scanning a patient who is taking a drug which affects blood clotting (clopidogrel, in Mr C's case). However, Adviser 1 told my complaints reviewer that the following factors should have raised concerns:

- Mr C had presented with a persistent headache lasting a week following a head injury;
- he had a sudden onset severe headache of nine out of ten severity precipitated by exertion and associated with nausea; and
- he was taking clopidogrel.

32. Adviser 1 said that, collectively, these factors should have prompted the doctors looking after Mr C to realise that he had a significant risk of bleeding in his head at that time. Adviser 1 said, therefore, a CT scan of Mr C's head should have been carried out. Adviser 1 also said that even if Mr C had not

reported suffering a fall and hitting his head, as he had reported a sudden onset severe headache on exertion which he described as nine out of ten in terms of severity and he felt his head was 'bursting' meant he may have been experiencing a subarachnoid haemorrhage of spontaneous onset. As such, Adviser 1 said an urgent CT scan was required to investigate for this.

33. In the opinion of Adviser 1, given the clinical features which Mr C presented with, it would only have been possible to conclude that Mr C had a minor head injury after he had a CT scan. In the absence of a CT scan, it was not reasonable to conclude that Mr C had suffered a minor head injury. Adviser 1 considered the decision not to carry out a CT scan of Mr C at this time, given his presenting clinical symptoms, was unreasonable and a significant failing. Adviser 1 told my complaints reviewer that if a CT scan had been carried out the possibility was that the bleed on Mr C's brain may have been detected at this time, when the bleed was likely to have been smaller and so may have allowed for treatment earlier.

34. Adviser 1 said the decision not to scan Mr C was a result of professional judgement rather than a systems failure. Adviser 1 considered the doctors involved should be asked to reflect on their practice.

Adviser 2

35. In the view of Adviser 2, there were indications for carrying out a CT scan which should have been applied in Mr C's case. These indications, in Mr C's case, related to Mr C reporting the sudden onset of a severe headache with or without a history of head injury. Adviser 2 said that, because of this, a CT scan should have been performed.

36. Adviser 2 noted that when a CT scan of Mr C's head was subsequently undertaken on 2 September 2015 when he returned to the ED (I have addressed Mr C's subsequent attendance at the ED in more detail in complaint (b) the findings indicated that Mr C had a large subdural haematoma of mixed signal consistent with fresh and recent haemorrhage. Adviser 2 said the appearances of the CT scan were consistent with an extensive blood clot having developed over the right hemisphere of Mr C's brain. Adviser 2 said there would have been a clot present on 22 August 2015, when Mr C attended the ED, and this would have been demonstrated if a CT head scan had been undertaken at this time. Adviser 2 told my complaints reviewer that the cause of the clot was most likely to have been the reported injury sustained by Mr C

when he fell getting out of bed whilst he was on holiday. Adviser 2 added that even if the clot had arisen spontaneously without Mr C sustaining the fall the implications of what followed would have been the same.

37. Adviser 2 explained to my complaints reviewer that the natural history of a subdural haematoma was to progressively increase in size, therefore increasing the intracranial pressure and resulting in pressure on the surface of the brain and a shift of the intracranial contents (the brain and ventricles) away from the clot. The pressure on the surface of the brain would progressively increase over time.

38. Adviser 2 said that, had the CT scan of Mr C's head been performed on 22 August 2015, the scan would have shown a surface collection (the subdural haematoma) and perhaps some evidence of pressure on the brain surface and associated shift. Adviser 2 also said between 22 August 2015 and 2 September 2015, when the CT scan was performed, these appearances would have progressed. Adviser 2 said an extensive shift, demonstrated on the CT scan which was carried out on 2 September 2015, would have carried an increased risk of a worse outcome for Mr C in terms of his neuropsychological and cognitive function.

39. Adviser 2 told my complaints reviewer that earlier diagnosis and treatment would have resulted in Mr C's earlier admission and treatment, with the potential for a significantly better recovery than occurred. Adviser 2 considered it was probably the case that the delay in admission and treatment has had a significant adverse effect upon Mr C's outcome. While Adviser 2 said it was not possible to quantify the effect, they had noted from Mr C's medical records the change in his condition over a period of two days between 2 and 3 September 2015. Adviser 2 noted that Mr C was mildly confused but appeared to understand the reason for his admission on 2 September 2015 and there was no other neurological abnormality at that time. On 3 September 2015, however, while he was aware of the date and obeying commands, his GCS was 14 due to confusion, he was projectile vomiting without warning, he had slurred speech, his right eye pupil was sluggish and larger than the left and he was incontinent.

40. Adviser 2 said Mr C's subsequent medical records documented that he went on to develop a right parietal infarct (a stroke) with evidence of poor short-term recall and information retention, in keeping with frontal impairment. Furthermore, Mr C went on to develop seizures. Adviser 2 said while these

seizures may have developed in any event following the craniotomy, it was the case that the seizures were more likely to have developed due to the more prolonged raised intracranial pressure and the associated shift as described in paragraphs 37 and 38 above.

41. Adviser 2 told my complaints reviewer that while an estimate of the extent of the resultant cognitive damage caused to Mr C can only be speculative, it was reasonable to state that the difference in outcome for Mr C between diagnosis and treatment on 22 August 2015 and diagnosis and treatment on 2 September 2015 would have been significant. Adviser 2 said the failure to carry out a CT scan at the correct time when Mr C presented to the ED on 22 August 2015 had led directly to delays in Mr C's treatment. Adviser 2 was of the opinion that the delay in investigation and treatment has had an adverse effect on Mr C's outcome. Adviser 2 told my complaints reviewer that, in the event that diagnosis and treatment had been made sooner, there would in all probability have been a significantly improved prognosis for Mr C.

42. Adviser 2 said the failure by the medical staff to appreciate the significance of a patient presenting with a sudden onset of severe headache (whether following a head injury or spontaneously) was a serious failing and said that all staff coming into contact with such patients should be warned of this potential.

(a) Decision

43. I note that Adviser 1 was of the view that the SIGN guidance is not prescriptive with regard to providing clinicians with definitive guidance on the scanning of a patient who presents with a delayed head injury and is taking medication which affects blood clotting.

44. Nevertheless, the advice I have received is that an urgent CT scan of Mr C's head should have been carried out when he presented to the ED on 22 August 2015, given his presenting symptoms. These were that Mr C had reported suffering a fall and hitting his head with loss of consciousness; he then had a persistent headache lasting a week; he had suffered a sudden onset severe headache of nine out of ten severity brought on by exertion and associated with nausea the day of his attendance at the ED; and he was taking clopidogrel. The advice was that, collectively, these factors should have prompted the doctors looking after Mr C to realise that he had a significant risk of bleeding in his head at that time.

45. Furthermore, even if Mr C had not reported suffering a fall and hitting his head, he had presented to the ED with a sudden onset severe headache on exertion which he described as nine out of ten in terms of severity and he felt his head was 'bursting'. This meant he may have been experiencing a brain haemorrhage of spontaneous onset and an urgent CT scan required to be carried out to investigate for this.

46. The advice I have received is that the decision not to carry out a CT scan of Mr C's head on 22 August 2015, given his presenting clinical symptoms, was a significant and serious failing. Also the failure to carry out a CT scan had delayed Mr C's diagnosis and treatment and adversely affected his outcome. If the diagnosis and treatment had been made sooner there would in all probability have been a significantly improved prognosis for Mr C. I accept this advice.

47. I am critical of the failing. I am satisfied that the standard of clinical care and treatment Mr C received when he presented to the ED on 22 August 2015 given his presenting symptoms was unreasonable. Accordingly, I uphold the complaint.

48. I appreciate that Mr C and Mrs C will find this a difficult and distressing outcome. Recognising that, and with the aim of saving others potentially having the same experience, in addition to the specific recommendation in relation to Mr C and Mrs C, I have focused on actions I recommend the Board take to improve their services.

49. I have made recommendations to address the failings identified at the end of this report.

(b) Hospital 1's ED failed to take reasonable action when Mr C attended there in September 2015

Concerns raised by Mrs C

50. Mrs C said she took Mr C back to the ED on 2 September 2015 as he was suffering with a constant headache. Mrs C said she had to 'beg' medical staff before they agreed to carry out a CT scan.

The Board's response

51. The Board said Mr C returned to the ED on 2 September 2015 at 14:42 with a constant and all over headache, not relieved by paracetomol. Mr C said he had been unable to work due to the headache. He was triaged by a nurse (Nurse 1) and advised to wait in the ED main waiting room. Nurse 1 recorded Mr C as having a further complaint relating to a minor head injury, and that his GCS at this time was 15 out of 15. The Board said it was likely that Nurse 1 had access to Mr C's records from his previous attendance at the ED on 22 August 2015. As Mr C was attending with a problem related to a previous injury more than three days old and his GCS was 15 with normal observations, he was judged to be a 'minors' patient. The Board said this was not unusual with patients who were presenting with symptoms that had been present for some time, as they were likely to be well enough to wait for a period before being assessed by medical staff.

52. The Board confirmed Mr C was first seen by a junior clinical fellow (Doctor 4), at 15:52. Mr C at the time had advised he had no nausea or vomiting, although his oral intake had reduced. Doctor 4's assessment of Mr C had highlighted no abnormalities and his impression of Mr C was that he had an ongoing post-head injury headache. However, Mr C's presentation was discussed immediately with Doctor 3, who was the ED consultant on duty at the time. The Board said Doctor 3 had carried out an immediate review of Mr C and agreed that he required a CT scan of his head. According to the Board, both Doctor 3 and Doctor 4 had explained to Mr C and Mrs C, who was also present, that Mr C would require a CT scan. Both doctors said they had no recollection of Mrs C being dissatisfied at this time.

53. The Board said the decision to perform a CT scan was made as soon as Doctor 3 had reviewed Mr C. The Board said Doctor 3 had apologised for Mrs C feeling she had to beg for Mr C to have a CT scan. However, Doctor 3 was of the view that Mr C had been managed in an appropriate and timely manner by Doctor 4.

54. The Board said that, following the results of the CT scan and the discovery that Mr C had suffered a haemorrhage, Doctor 3 had immediately communicated with the neurological team at Hospital 2 and made arrangements to have Mr C transferred there. In the meantime, Mr C was transferred to the major area of the ED so that he could be closely monitored and 30 minute

observations were carried out until Mr C's transfer by emergency ambulance to Hospital 2 at 18:40.

55. The Board said Doctor 3 had concluded that Mr C was treated appropriately during this attendance at the ED.

Medical Advice - Adviser 1

56. Adviser 1 said Mr C had re-presented to the ED at 14:42 on 2 September 2015. It was not clear to Adviser 1 what triage category Mr C was allocated. Adviser 1 noted that Mr C was seen by Doctor 4, a junior doctor, at 15:25 who documented the mechanism of Mr C's injury and the fact that his presenting complaint was a constant headache at this time. Adviser 1 said Doctor 4 had documented a thorough history and examination of Mr C which was of a reasonable standard.

57. Adviser 1 advised that it was reasonable to have initially judged Mr C to be a 'minors' patient because he was fully conscious and his vital signs were normal (except for a moderately elevated blood pressure). Also, his headache on this occasion was not severe or of sudden onset.

58. Adviser 1 was asked if there was any evidence that there was a reluctance to carry out a CT scan. Adviser 1 said there was no evidence of this in the medical records. Adviser 1 noted that Doctor 4, on first seeing Mr C, had documented the possible need for a CT scan, that Mr C's case was discussed with Doctor 3 and a decision made to scan him at that point. Adviser 1 said the CT scan was carried out at 16:18, which indicated that it had been carried out very quickly after it was requested. Adviser 1 said what had occurred was reasonable.

59. Adviser 1 also said there was also no delay in contacting the neurosurgeon at Hospital 2 once the CT scan result was available. It was documented that Doctor 4 had 'called back' the neurosurgeon and Mr C was accepted for transfer to Hospital 2 at this time. In the view of Adviser 1, there was no unreasonable delay in assessing and treating Mr C, who was seen in an appropriate timescale by Doctor 4. Adviser 1 said the standard of care given to Mr C on this occasion was timely and was of an excellent standard.

(b) Decision

60. Mrs C and the Board have differing views about what happened when Mr C re-attended at the ED on 2 September 2015. I appreciate Mrs C's concern, in particular, given what occurred when Mr C had first attended the ED on 22 August 2015. However, taking account of the evidence and the advice I have received from Adviser 1, in particular, that the standard of care given to Mr C on this occasion was timely and was of an excellent standard, I am unable to conclude that the care provided to Mr C on 2 September 2015 was unreasonable. Therefore, I do not uphold this complaint.

(c) The nursing care provided to Mr C while he was in the Ward of Hospital 1 was unreasonable

Concerns raised by Mrs C

61. On 13 October 2015 Mr C was transferred from Hospital 2 to Hospital 1. Mrs C complained about the nursing care Mr C received during this admission. Mrs C said she was unhappy with the care and treatment Mr C had received while he was in the Ward and with the attitude of some of the nursing staff towards both Mr C and herself.

62. Mrs C said her main concerns were that Mr C was considered to be at high risk of falls, which was documented in his nursing records, and he required assistance when mobilising. Mrs C said, however, when she had raised with nursing staff Mr C's need to be assisted when mobilising, his records in relation to his mobility were changed and it was recorded that he could mobilise independently. Mrs C questioned what assessment had been carried out to justify the change in Mr C's mobility status.

63. Mrs C said staff were often not available when Mr C required to go to the bathroom and so she had to assist him as she was concerned for his safety. Mrs C said on a number of occasions she found the toilet in an unhygienic state. On one occasion when she complained and asked a member of the nursing staff for the toilet to be cleaned, Mrs C said the staff member was rude and abrupt to her.

64. Mrs C said Mr C's personal hygiene needs were not appropriately attended to. Mrs C said on a number of occasions she found Mr C 'dirty' and his shaving razor had been removed. Although Mrs C accepted that Mr C's behaviour was difficult at times, she considered he should have been assisted to wash and been provided with clean clothes. Mrs C said she and her family

had to assist with Mr C's personal hygiene needs. Mrs C said when Mr C had been cared for by an agency nurse he was well looked after and questioned why Ward staff could not do the same for Mr C.

65. Mrs C said nursing staff failed to notice and ensure that Mr C took his medication. Also, a urine sample to check whether Mr C had a urine infection had been left unattended for four days.

66. Mrs C said she felt that nursing staff could not manage Mr C when he was in a confused state. According to Mrs C, Mr C was manhandled by nursing staff and a member of staff had unreasonably tried to forcibly sedate Mr C with the use of a syringe. Mrs C said Mr C had telephoned home crying to say he had been 'assaulted'. Mrs C said staff had later removed the battery from Mr C's mobile phone so he could not use it. Mrs C questioned why she was telephoned late at night regarding Mr C's behaviour and told staff had required to send for security because of Mr C's behaviour. Mrs C said she felt that the attitude and behaviour of nursing staff towards Mr C had aggravated his confused state. Mrs C said she had to constantly stay with Mr C to keep him safe.

67. Mrs C also questioned the use of a bell on the Ward. Mrs C said the noise of the bell which staff would ring directly outside Mr C's room caused him to be agitated and disturbed his sleep. Mrs C also said Mr C's sleep was constantly disturbed by night staff talking and laughing outside his room and by staff entering the room early in the morning with drinking water for Mr C. Mrs C said Mr C had asked for an additional blanket because he was cold but his request was not acted upon and she had to provide Mr C with a duvet cover from home.

68. Mrs C said nursing staff unreasonably refused permission for family members and friends of Mr C to take him out of the Ward for a coffee. According to Mrs C, there had been a false report made by nursing staff that on one particular occasion Mr C had left the Ward with a visitor without permission who had then subsequently left Mr C unattended. Mrs C said this had caused unnecessary upset to Mr C.

69. Mrs C said the poor experience endured by Mr C in the Ward had left them and their family traumatised.

70. Mrs C attended a meeting with the Board in January 2016 to discuss her concerns and subsequently received a letter of response from the Board about those concerns. Mrs C was dissatisfied with the Board's response and so complained to my office.

The Board's response

71. Following Mrs C's meeting with the Board on 13 January 2016 to discuss her concerns, the Board wrote to Mrs C. The Board said Mrs C's concerns had been discussed with the senior charge nurse on the Ward (Nurse 2), at the time of Mr C's admission.

72. The Board said a falls risk assessment of Mr C was carried out and his high risk status was based on a number of factors. Although Mr C was deemed independently mobile he was still at high risk of falls due to his confusion and disorientation from his head injury. The Board acknowledged that Mr C would have benefited from constant supervision, however, the Ward was unable to provide this at all times. The Board said a number of preventative measures were put in place to reduce Mr C's risk of falling including where he was placed on the Ward, regular monitoring and being nursed on an ultra-low bed, which is designed to reduce the risk of patients falling from their bed.

73. The Board said Mr C was also regularly assessed by a physiotherapist and as his mobility improved he was deemed able to mobilise. The Board accepted that this assessment was not updated on the Ward's whiteboard until Mrs C challenged this.

74. The Board said that concerns Mrs C had raised about the attitude of a member of staff concerning her request to have the Ward toilet cleaned had been discussed with the particular member of staff. The Board apologised that Mrs C had received an inappropriate response to her request and that this had been addressed with the staff member concerned.

75. The Board said Mr C was assisted with his personal hygiene. However, due to the dependency levels of a high number of patients on the Ward Mr C's daily personal care had taken longer than normal. Nurse 2 reported that at times Mr C's behaviour was challenging and on occasions he refused to allow staff to assist him with his personal hygiene. The Board said they were sorry if, on occasions when Mrs C visited, Mr C was unclean. The Board also said Mr C's razor was removed for safety purposes, mainly due to his confusion.

76. The Board said that on occasions Mr C had refused his medication, which was recorded in the prescription chart in his medical records. The Board said that nursing staff were required to adhere to the Board's Administration of Medicine policy and observe patients taking their prescribed medication. The Board said any non-compliance with this policy was taken seriously and this had been addressed with the nursing team. The Board said, however, there was no evidence to suggest that Mr C was held down and sedated. Nurse 2 also confirmed that Mr C's urine sample was tested.

77. The Board explained that there were circumstances when patients display challenging behaviour and when this occurred their next of kin was contacted, as patients often responded more positively to a family voice or face. The Board said Mr C's nursing records documented that Mrs C had been contacted on one occasion when Mr C was extremely unsettled and staff could not get him to take his medication.

78. The Board said a doctor in the Ward (Doctor 5) who spoke to Mrs C had explained to her that Mr C's behaviour towards staff was exaggerated at times as a result of his brain injury. Doctor 5 had also explained Mr C's brain injury had resulted in changes to Mr C's personality and behaviour and short-term memory and that it was not uncommon for matters to be made up and the truth distorted.

79. The Board said, in relation to the concerns about Mr C being disturbed, the Ward bell was only rung to alert staff to a twice daily safety brief. Mrs C's concerns had been discussed with the nursing staff who had been asked to reflect on how this was impacting on patients and for an alternative method of gathering staff to the meeting be considered. The Board said Mr C was cared for in a side room on the Ward opposite the nurses' station so as to allow for good observation and it was, therefore, likely that he heard conversations between nursing and medical staff during the night. Staff had been reminded to maintain a quiet and settled environment to promote sleep. They explained that water jugs were removed late at night for washing and then replaced at 06:00 so that patients had access to fresh water on waking. Nurse 2 also said Mr C was not refused a blanket when he had complained about being cold and the temperature in his room was increased.

80. The Board said Mrs C's concerns about Mr C leaving the Ward for a coffee had been discussed with Nurse 2. The Board explained that, in circumstances where patients are confused, nursing staff may advise against them leaving the ward. The Board said they were sorry for the confusion surrounding the incident where it was alleged that a friend of Mr C had removed him from the Ward and left him unattended. The Board said this was due to miscommunication and misunderstanding around the event.

81. The Board acknowledged that this was a difficult time for Mrs C and that Mr C's care had at times fallen short of the standard they would expect. They apologised to Mr C and Mrs C for their poor experience and that their relationship with some of the nursing staff was less than satisfactory. Nurse 2 had been asked to share the concerns raised by Mrs C with the nursing staff and for the staff to reflect on this and consider how Mr C's care could have been better.

Nursing Advice

82. Adviser 3 said they had reviewed all the nursing records in detail. Adviser 3 noted that Mr C had been a patient at the neurosurgical unit of Hospital 2 and on 3 September 2015 had a craniotomy for an acute subdural haematoma. Thereafter, Mr C was in intensive care and then transferred to a ward. Adviser 3 said it was documented that Mr C had suffered many seizures, was agitated at times and was reported to be at high risk of falls at the time of his transfer to Hospital 1. It was also documented in Hospital 2's nursing records that Mr C required constant care due to his agitation, confusion and falls risk.

83. Adviser 3 said Mr C was suffering from a brain injury and an Adults With Incapacity certificate was in place. Adviser 3 considered this was appropriately taken into account by staff in the nursing care Mr C received.

84. Adviser 3 said the assessment of Mr C's falls risk was documented almost daily in the nursing records as part of his on-going assessment for nursing care. Adviser 3 said Mr C's falls diary and falls care plan were in order and there was evidence of good practice. There was also evidence in the nursing records that Mr C was regularly seen by a physiotherapist and in late October 2015 he was noted as being independently mobile. Nevertheless, Adviser 3 told my complaints reviewer that although Mr C had been assessed as requiring constant observation due to his high risk of falling this had not been provided

and Mr C had suffered a number of falls. Adviser 3 was critical of this and said that systems must be in place to ensure adequate staffing levels are available when required which may include escalation to senior management. Adviser 3 was of the view that, as a result, Mr C's nursing care fell short of providing him with reasonable observation.

85. Adviser 3 said nursing staff appeared to have attended to Mr C's personal hygiene when he accepted care. The nursing records clearly stated when Mr C did not accept assistance. Adviser 3 noted there were daily entries of what personal care took place and whether or not Mr C accepted assistance. For example, some days Mr C accepted assistance to shave but not to shower. Adviser 3 told my complaints reviewer this approach was reasonable and understandable and they considered the nursing staff were correct in the way they managed Mr C's care.

86. Adviser 3 said there were some gaps in record-keeping in relation to Mr C's nursing records, in particular, the assessment of capacity and consent/violence and aggression assessment. Whilst Adviser 3 considered the nursing records contained a comprehensive assessment and monitoring of falls and behaviour, this remained an omission in the records.

87. Although Adviser 3 identified variances in the bedrail assessment and use, they considered this aspect of Mr C's care to be reasonable. Adviser 3 was of this view because nursing staff were continually assessing the falls risks and subsequent care required for Mr C, taking into account his transient state of mind and resultant behaviours. Adviser 3 said the need for bedrails could vary and the nursing records indicated there was on-going assessment of risk.

88. Adviser 3 was of the view that nursing staff had complied with their administration of medicine policy in relation to Mr C's medication and there was good record-keeping about when Mr C declined his prescribed medication. Adviser 3 said there were also clear accounts from nursing staff about referring Mr C to medical staff for review of his medication. Adviser 3 considered that caring for a patient like Mr C was difficult for staff as a balance had to be struck between managing Mr C's behaviour positively, administering medication to reduce his agitation and not to promote overt drowsiness which would have increased his falls risk. In summary, Adviser 3 considered the care and administration of Mr C's medicines was reasonable.

89. Adviser 3 said there were frequent reviews and discussions by a multi-professional team about how best to manage Mr C's behaviour and the medications to be used. Ultimately, the most successful outcome was to have Mrs C to stay in the room overnight. Adviser 3 said although this may have been difficult for Mrs C, this approach allowed Mr C to sleep, settle and, in turn, the nursing staff and other patients had a better outcome too.

90. Adviser 3 told my complaints reviewer that Mr C's brain injury had caused him to exhibit behaviour, which could be difficult to manage. Adviser 3 said, however, that the nursing records indicated that nursing staff had carried out their care in a professional manner and always with the intention of providing dignified care to Mr C.

91. With regard to Mrs C's concerns about the actions of night nursing staff and ringing a bell on the Ward, Adviser 3 said there was evidence that Mr C was generally unsettled overnight and this was when most of the incidents occurred. Adviser 3 considered the incident surrounding the cleanliness of the Ward toilet was unfortunate.

92. Adviser 3 told my complaints reviewer this was one of the most distressing complaints they had seen. Adviser 3 said managing patients with a brain injury such as Mr C can be difficult for nursing staff. Adviser 3 noted there were incidents where nursing staff were uncomfortable and felt unsafe in the presence of Mr C. There was also evidence in the nursing records suggesting that at times Mrs C was understandably very distressed about Mr C's nursing care and relationships between her and the nursing staff on the Ward appeared to be strained.

93. Adviser 3 said it was unclear whether the Board had a system of escalation to senior nursing staff for requesting enhanced observations for patients with a brain injury and caring for them. Although Adviser 3 said that Mr C did not have a mental health condition, it was also unclear whether consideration had been given to involving the mental health nursing service to advise staff who were caring for Mr C.

94. Adviser 3 said the Board should provide a supportive training session to assist nursing staff when caring for patients who have suffered a brain injury and for caring for patients with challenging behaviour, if this has not already been done.

95. Adviser 3 also commented that in large acute hospitals, the Board may wish to consider having a dedicated ward/part of a ward where patients who have suffered a brain injury and/or exhibit challenging behaviour can be cared for jointly by acute and mental health teams with appropriate staffing levels.

(c) Decision

96. I have considered and taken into account the evidence provided by Mrs C and the Board, and, in particular, the independent advice I have received from Adviser 3, whose advice I have set out above.

97. I acknowledge Mrs C's strength of feeling and her distress and concerns about Mr C's nursing care, particularly given all that Mr C had endured. The Board have acknowledged this was a difficult and upsetting time for Mrs C and they identified a number of issues where Mr C's care, and communication with Mrs C had at times fallen short of the standard Mrs C expected and they have apologised. I also acknowledge that the Board have said these matters were addressed with the nursing staff concerned and the Ward staff had been asked to reflect and consider how Mr C's care could have been better.

98. The advice I have received from Adviser 3 is that Mr C's brain injury had caused him to exhibit behaviour which was at times difficult to manage. While Adviser 3 considered there were many aspects of Mr C's nursing care which were reasonable, they identified failings in his care in relation to providing Mr C with reasonable observation given he was at high risk of falling and he had suffered a number of falls as a result. Adviser 3 was critical of this and the system that was in place at the time. I accept that advice.

99. Adviser 3 also identified shortcomings in record-keeping in relation to Mr C's nursing records.

100. Given the advice I have received, I consider, that, on balance and in the circumstances of this case, the nursing care provided to Mr C in the Ward was not reasonable as it did not meet the standards expected. Accordingly, I uphold this complaint.

101. Adviser 3, in their advice to me has commented on what action could and should be taken to address some of the issues which were identified with Mr C's

nursing care. I have made recommendations and addressed these matters at the end of this report.

Recommendations

What we are asking the Board to do for Mr C and Mrs C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a)	The Victoria Hospital's Emergency Department failed to carry out a CT scan of Mr C's head when he attended on 22 August 2015	Provide a written apology for the failure, that complies with the SPSO guideline on making an apology (available at https://www.spso.org.uk/leaflets-and-guidance)	Copy of the apology letter By: 19 August 2017

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Victoria Hospital's Emergency Department failed to carry out a CT scan of Mr C's head when he attended on 22 August 2015	The Board should reflect and learn from the comments of Adviser 1 and Adviser 2 for the management of patients with a head injury. This review should consider how learning from the specific incidents of this case, in particular, where patients present with a sudden onset of severe headache (whether following a head injury or spontaneously). The review should be used to inform the need for systemic improvement in this aspect of the Board's service	Documentary evidence that reflection has taken place and learning captured, such as copies of minutes of discussions of this report with the relevant staff and managers, internal memos/emails, or reports, and documentation showing feedback given By: 19 September 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Victoria Hospital's Emergency Department failed to carry out a CT scan of Mr C's head when he attended there on 22 August 2015	The Board should demonstrate they have acted on their learning to ensure their procedure for the management of patients with a head injury, in particular, where patients present with a sudden onset of severe headache (whether following a head injury or spontaneously) are fit for purpose and reduce the likelihood of a recurrence of the circumstances of this case	Documentary evidence of procedural review and subsequent change. This should include revised procedures with changes highlighted. It could include: copies of process audits, internal meeting minutes, review reports or a detailed explanation of the review and its conclusions / any resulting process changes By: 19 September 2017
(c)	Nursing staff caring for patients who have suffered a brain injury and for patients with challenging behaviour were not sufficiently well trained	The Board should ensure nursing staff caring for patients who have suffered a brain injury, and for patients with challenging behaviour, receive appropriate learning and development and that mechanisms exist to ensure this is kept up-to-date	Documentary evidence that these training needs are being met, or planned (with definitive timescales, not simply a broad intention) By: 19 September 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(c)	There were omissions in record-keeping in relation to the assessment of capacity and consent/violence and aggression assessment	The Board should ensure that systems are in place that ensure nursing records are maintained in accordance with the nursing and midwifery code of practice	Documentary evidence such as discussions about this report, changes that are (or have been) made as a result, and revised procedures or instructions to staff about the application of current procedures By: 19 September 2017

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(c)	The Board acknowledged that Mr C's care had at times fallen short of the standard Mrs C would expect	The Board said Mrs C's concerns had been shared with the nursing staff and staff had been asked to reflect on this and consider how Mr C's care could have been better	Documentary evidence of discussion of Mrs C's concerns with the relevant nursing staff at a staff meeting By: 19 September 2017

Feedback for Fife NHS Board

Complaint Number (c)

Points to note: Given the comments of Adviser 3, the Ombudsman recommends the Board give consideration to having a dedicated ward/part of a ward where patients who have suffered a brain injury and/or exhibit challenging behaviour can be cared for jointly by acute and mental health teams with appropriate staffing levels.

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

103. We will follow-up on these recommendations. The Board are asked to inform us of the steps 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.

104. When responding to a draft of this report, the Board told me that, having considered it, it would not be practicably possible to deliver the point noted in my feedback. Even so, they will make every effort to accommodate patients with this presentation within two specific wards of Hospital 1 where they have an acute psychiatric liaison service/unscheduled care team. The Board have also informed me that the supervision procedure for patients requiring one-to-one intensive supervision is currently under review. It is ultimately a matter for the Board, and I am pleased that they considered the feedback in relation to their services, seriously.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr C	the husband of Mrs C and the subject of this complaint
Hospital 1	Victoria Hospital, Kirkcaldy
ED	Emergency Department of Victoria Hospital, Kirkcaldy
Hospital 2	Western General Hospital, Edinburgh
the Ward	ward 42 of the Victoria Hospital, Kirkcaldy
the Board	Fife NHS Board
Adviser 1	a consultant neurosurgeon who provided medical advice on the treatment provided to Mr C
Adviser 2	a consultant neurosurgeon who provided medical advice on the treatment provided to Mr C
Adviser 3	a nurse who provided nursing advice on the treatment provided to Mr C
the SIGN guidance	Scottish Intercollegiate Guidelines Network guidelines on the Early management of patients with a head injury
GCS	Glasgow Coma Scale

Doctor 1	a doctor who assessed Mr C when he attended the Emergency Department of the Victoria Hospital, Kirkcaldy on 22 August 2015
Doctor 2	a doctor who reviewed Mr C when he attended the Emergency Department of the Victoria Hospital, Kirkcaldy on 22 August 2015
Doctor 3	a consultant in emergency medicine who Mr C when he attended the Emergency Department of the Victoria Hospital, Kirkcaldy, on 22 August 2015 and who investigated Mr C's care following Mrs C's complaint to the Board
Nurse 1	the nurse who triaged Mr C when he attended the Emergency Department of the Victoria Hospital, Kirkcaldy on 2 September 2015
Doctor 4	a doctor who assessed Mr C when he attended the Emergency Department of the Victoria Hospital, Kirkcaldy on 2 September 2015
Doctor 5	a doctor who spoke to Mrs C in Ward 42 of the Victoria Hospital, Kirkcaldy
Nurse 2	the senior charge nurse in Ward 42 of the Victoria Hospital, Kirkcaldy

Annex 2

Glossary of terms

Adults with Incapacity certificate	a certificate which allows medical treatment to people who cannot give their consent alphabetical order
atorvastatin	a cholesterol lowering medication
brain haemorrhage	a burst blood vessel that causes bleeding in the brain
clopidogrel	a medication used to reduce the risk of heart attack and strokes in persons with heart disease, previous stroke or other circulatory problems
computerised tomography (CT) scan	a scan that combines a number of x-rays to produce detailed imaging
craniotomy	a surgical procedure to open the skull in order to gain access to the brain
Glasgow Coma Scale	a scoring system used to describe the level of consciousness in a person with a brain injury
intracranial	within the head
neuropsychological	the relationship between the brain and behaviour
paracetamol	a medication used to treat pain
platelets	cells that circulate in the blood and clot to prevent bleeding
subarachnoid haemorrhage	bleeding over the surface of the brain

subdural haematoma	a clot of blood which collects between the skull and the surface of the brain
transient ischaemic attack	a temporary disruption in the blood supply to part of the brain
triage	an initial medical assessment to determine the urgency of the need for care

Annex 3

List of legislation and policies considered

SIGN 110 Guideline Early Management of Patients with a Head Injury