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: Glasgow

Case 201304738: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns with Greater Glasgow and Clyde NHS Board (the Board) regarding the care and treatment her father (Mr A) received while a patient in Glasgow Royal Infirmary (the Hospital). Mr A died in hospital on 26 November 2013.

Specific complaints and conclusions

The complaints which have been investigated are that the Board did not:

(a) provide reasonable care and treatment to Mr A between 25 October and 26 November 2013 (*upheld*);

(b) communicate reasonably with Mr A's family between 25 October and 26 November 2013 (*upheld*); and

(c) respond reasonably to Mrs C's complaints about these matters (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensure its policies set out clear responsibilities for clinicians to ensure that tests are either reviewed by the requesting doctor, or handed over to colleagues;	29 April 2015
(ii) carry out a morbidity and mortality case review of Mr A's death. The review should include the actions of the Haematology and Orthopaedic departments and provide evidence that the following points were addressed: the handover procedures followed by medical staff; the care and treatment pathways for the management of patients who fracture their hip whilst on a geriatric ward; the failure to ensure that Do Not Attempt	20 July 2015

	Cardio-Pulmonary Resuscitation was discussed appropriately with the patient or his family; whether the Board's end of life care policies were properly followed; whether Mr A's mental capacity was properly assessed and what procedure should have been followed; review whether there was appropriate and timeous discussion of resuscitation with Mr A's family; review the failure to document in Mr A's records the reason for his ward transfer; review the lack of early Consultant input into case discussions with Mr A or his family;	
(iii)	include the findings of the morbidity and mortality review in the subsequent appraisal of the consultant responsible for Mr A's care;	18 September 2015
(iv)	remind all staff of the importance of documenting and signing discussions with patients' families;	15 April 2015
(v)	apologise for the failings identified in this report; and	15 April 2015
(vi)	provide evidence that the actions referred to in the complaint response letter have been implemented.	15 April 2015

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

Main Investigation Report

Introduction

1. Mr A was an 88-year-old man, who suffered from myelodysplasia. This condition causes the bone marrow to malfunction. Blood cells are not produced in sufficient numbers and those that are produced are of poor quality. Mr A, therefore, required regular blood transfusions to prevent him developing severe anaemia. It also meant Mr A was very vulnerable to infections and was at increased risk of bruising and bleeding.

2. Mr A had been becoming increasingly frail for several months prior to his hospital admission. His mobility had deteriorated and he had sustained several falls. Mr A had been becoming confused and had a Mini Mental State Examination (MMSE) (a measure of brain function or failure) score of 11-19/30 on 13 August 2013. This implied that Mr A had developed a significant impairment of his cognitive or thinking abilities.

3. Mr A was admitted to the Glasgow Royal Infirmary (the Hospital) on 25 October 2013 through Accident and Emergency suffering from neutropenic sepsis. This meant Mr A had developed a life threatening infection due to the inability of his bone marrow to produce enough white blood cells to fight the infection.

4. Mr A was transferred from Ward 50/51 where he had been since his admission to the Hospital on 7 November 2013. Mr A's daughter (Mrs C) has complained that the reasons for this transfer were not explained to the family. Following this transfer, Mr A suffered an unwitnessed fall, resulting in a fracture to his left hip and pelvis.

5. Mrs C and other members of her family were sufficiently concerned to make a formal complaint about Mr A's care and treatment in late November. Mrs C was concerned there was a lack of communication with the family, as visiting times coincided with shift handover, which meant staff were unavailable to speak to family members. She felt that the family's concerns were consequently not being taken seriously.

6. Mrs C was also concerned that Mr A's hip was not x-rayed for several days, even though he was clearly in pain. Although he was referred for x-ray, the family were told his knee had been x-rayed rather than his hip. Mrs C

complained that Mr A's hip was not x-rayed until some ten days after his fall. Mrs C was particularly upset that following the x-ray, the family were suddenly presented with a choice between an operation with a significant possibility of a fatal outcome or Mr A receiving palliative care only.

7. Following discussions with medical staff Mrs C and her family made the decision not to proceed with medical care for Mr A. Mr A died in hospital on 26 November 2013 following unsuccessful attempts at cardio-pulmonary resuscitation (CPR).

8. The complaints from Mrs C which I have investigated are that Greater Glasgow and Clyde NHS Board (the Board) did not:

(a) provide reasonable care and treatment to Mr A between 25 October and 26 November 2013;
(b) communicate reasonably with Mr A's family between 25 October and 26 November 2013; and
(c) respond reasonably to Mrs C' complaints about these matters

Investigation

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

10. 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.

(a) The Board did not provide reasonable care and treatment to Mr A between 25 October and 26 November 2013

11. Mrs C complained that Mr A had been transferred inappropriately from Ward 50/51, which he had originally been admitted into, to Ward 19. She said the reason for this transfer had not been explained to the family.

12. Mrs C said that she had been told Mr A had fallen when getting out of bed on 9 November 2013. Mrs A said that although they were not given a clear explanation of what had happened to Mr A, they were told he had been

provided with pain relief and that he would be x-rayed as soon as possible. Mrs C said that over the next three to four days, they repeatedly asked when Mr A would be x-rayed but the family were told that they would have to wait.

13. Mrs C said when the x-ray was performed on 11 November 2013, the family were told there were no breaks. They were subsequently informed that Mr A's knee had been x-rayed rather than his hip. There was a further delay of some five days before Mr A's hip was x-rayed. When Mr A was x-rayed, a broken hip was diagnosed, although Mrs C noted this was now some ten days after he had originally fallen.

14. Mrs C felt that the family were then put in an impossible position, as they were advised it was likely Mr A would not survive an operation to repair the damage to his hip. Mrs C said the family believed the failure to identify Mr A's hip fracture sooner had meant it was not possible to repair it and that it had hastened Mr A's death. Mrs C said the family believed Mr A had suffered unnecessarily during his stay in hospital.

The Board's Position

15. The Board set their position out in a letter to Mrs C on 30 December 2013. The Board said Mr A was admitted in October 2013 in a complex medical condition caused by deterioration in his blood cells. He was very vulnerable to infection, due to a reduced number of white blood cells.

16. The Board said that Mr A was placed in a single room in Ward 18/19 to reduce the risk to him of further infection. Mr A was recorded as sustaining an unwitnessed fall on the evening of 9 November 2013. He was found by nursing staff sitting on the floor by his bed. The medical assessment carried out at the time indicated that his knee and shoulder were causing Mr A discomfort and an x-ray of the knee was requested. The Board did not believe that hip injury was indicated at that time.

17. The Board said that Mr A's knee was not considered to need an urgent x-ray, however, the expectation was that it would be performed the following day on 10 November 2013, in the event, Mr A's knee had been x-rayed on 11 January 2013 . The Board said the card requesting Mr A's knee x-ray had not been received by the X-ray department until 30 hours after it had been filled out. The Board were unable to explain this delay, and apologised for the failure in their internal systems.

18. The Board said on 10 November 2013 Mr A had been reviewed and pain and a reduced range of motion in his hip was noted. The record showed an x-ray of his hip and pelvis had been proposed. He was reviewed again on 11 November 2013 and the need to chase the x-ray requested for him on 10 November 2013 was recorded in his notes. The Board noted there was in fact no record of a formal x-ray request having been completed on 10 November 2013, although staff would not immediately have been aware of this.

19. The Board said that Mr A was reviewed again on 12 November and it was decided that unless he displayed further symptoms of hip pain, no x-ray of his hip would be required. Mr A subsequently developed further pain in his hip and an x-ray was requested on 14 November 2013. The x-ray was carried out on 16 November 2013 and the results were reviewed on 17 November 2013, when a fractured hip was diagnosed. The Board said that Mr A's medical condition meant he was not considered capable of undergoing major surgery. The Board said Mrs C had discussed the case with medical staff and agreed that Mr A should be managed palliatively.

20. The Board accepted there were delays between the fall on 9 November 2013 and the diagnosis of a fractured hip on 17 November 2013. They said that delays were not uncommon when a patient did not have major initial symptoms. The Board believed Mr A was likely to have suffered an impacted fracture (when the bones initially remained knitted together), before a delayed presentation with major symptoms when the bones separated. The Board said they believed this to be the case for Mr A and that Mrs C had agreed that Mr A should be managed conservatively.

21. The Board said it was appropriate that the x-ray request submitted on 10 November 2013 was not urgent, given the symptoms displayed by Mr A at that time, which they believed indicated he was unlikely to be suffering from a hip fracture. They accepted, however, that when it became apparent on 14 November 2013 a hip x-ray was required, it should have been carried out immediately, rather than waiting until 16 November 2013. The Board said they had established that the X-ray department had had difficulty in contacting Ward 19 to request Mr A be brought for x-ray, but they had not been able to establish why this had happened.

22. The Board said they had identified three factors in the delay in providing Mr A with an x-ray. Mr A had not initially complained of hip pain and the on-call doctor who had attended him had not completed an x-ray request, leading to delays in medical staff requesting the appropriate x-ray. The Radiology department had not received the x-ray request card, resulting in further delays and the clinical team had not then reviewed the x-ray timeously.

23. The Board said they had reviewed their protocols for requesting x-rays following a fall. The Board said although the delay in diagnosing the hip fracture did not represent good practice, it had not influenced Mr A's outcome. They were of the view that, given his medical condition at the time, he would not have been able to undergo surgery.

Clinical Advice Obtained

24. The Adviser set out a chronology of Mr A's care and treatment which he had compiled from the medical notes. He said, in his view, this helped to clarify the care and treatment Mr A had received. For clarity I have added additional headings to the chronology to reflect the different stages of Mr A's care.

Ward Transfer

25. The Adviser said there was no documentation to show why Mr A was transferred out of Ward 50/51 to Ward 18/19 on 7 November 2013. It was, therefore, difficult to make any definitive comment on the appropriateness of the decision to transfer Mr A. The Adviser said that the Board should have local guidelines to ensure consistent care was provided to patients with neutropenic sepsis, broadly based on national guidance with local amendments made by the resident Haematology team.

26. The Adviser also said the evidence available did not show the decision to move Mr A was based on infection control issues, or the availability of side rooms. The Adviser said the notes did show regular review by the Haematology team whilst on Ward 50/51 and this aspect of his care was appropriate. The Adviser was also satisfied that appropriate advice and guidance was sought from the Haematology team, following Mr A's transfer.

Care and treatment of Mr A following his fall

27. The Adviser said that on 9 November 2013 the notes showed a junior doctor (Doctor 1) had reviewed Mr A, following an unwitnessed fall in his room.

Doctor 1's examination was recorded in the notes, and an x-ray was ordered for the next working day. No indication was given of the area to be x-rayed.

28. The Adviser said that an x-ray of the pelvis and hips should have been requested urgently if there was any clinical suspicion of fracture. The degree of suspicion would have been determined by the clinical context and an examination of the patient. He noted Mr A's severe infection would have further compromised his already diminished cognitive abilities, due to delirium (an acute disturbance of the brain, which reduces brain abilities and causes confusion and agitation or apathy, usually due to infection). This should have raised the suspicion that Mr A would be unable to describe his pain accurately. The fact that the fall was unwitnessed also increased the difficulty in establishing accurately what had happened.

29. The Adviser observed that the clinical record of the examination was not well documented and it was not possible to say if it was complete or competently performed. He noted, however, that Doctor 1 did record that assessment of the legs was not possible due to the pain Mr A was experiencing. The Adviser said this should have heightened the suspicion of a fracture.

30. The Adviser also said it would have been reasonable at this stage to have performed an urgent x-ray of the hip and pelvis. Mr A was clearly not able to give an account of his fall or describe his injuries. There should have been a high suspicion on the part of clinicians of fracture to the hips or pelvis, even in the absence of classical signs. Additionally the type of x-ray requested and the area to be x-rayed should have been clearly documented. The x-ray should have been performed and reviewed urgently, with prompt follow up actions.

31. The Adviser went on to say that on 10 November 2013, the notes showed Mr A was reviewed by a specialist registrar (Doctor 2). Doctor 2 noted Mr A had 'mild pain' in his hip and was unable to get out of bed. His left leg was externally rotated and had limited movement. The Adviser said this was a 'classical' sign of hip fracture. Although an x-ray of the hip and pelvis was noted as required, there was no indication the request had been actioned. The Adviser said that again there was a high suspicion of a fractured hip and Doctor 2 should, therefore, have urgently requested an x-ray. Once the result had been obtained, it should have been reviewed as a priority and orthopaedic involvement sought. If Doctor 2 was unable to do this, an adequate handover to

the relevant team should have been carried out, with instructions for urgent review of the x-ray and appropriate action to be taken.

32. The Adviser said that Mr A was reviewed by another junior doctor (Doctor 3) on 11 November 2013. Although a note was made to chase the x-ray of the hip and pelvis, nothing further was done. On 12 November 2013 Mr A was seen by a consultant (Doctor 4). The entry in the case notes included prescription of a beta blocker and notes on the management of a heel sore, with antibiotic therapy for infection. No mention was made of a management plan for Mr A's hip following his fall.

33. On 16 November 2013 an x-ray was performed, although the Adviser said it was only possible to ascertain this retrospectively, as there was no entry in the notes recording this event. The x-ray was reviewed on 17 November 2013. A chest x-ray had also been carried out and the results of the x-rays showed fractures to the left hip and pelvis as well as pneumonia. A consultant (Doctor 5) explained the diagnosis to Mrs C and also explained that the decision over whether to carry out surgery was a complicated one, and needed careful consideration. The medical records show that at this point, Mrs C raised concerns about the treatment Mr A had received on the ward and was advised to take these up with the ward manager.

34. Doctor 5 initiated an urgent review by the Orthopaedic team and Mr A was reviewed by the on-call orthopaedic junior doctor (Doctor 6). Doctor 6 decided Mr A was not suitable for immediate surgery, because of his chest infection and his abnormal blood count. Doctor 6 contacted the Haematology team to advise them of the fracture and the possibility of surgery.

35. On 18 November 2013 Mr A was reviewed by a senior registrar (a junior doctor, albeit almost at consultant level) (Doctor 7). Doctor 7 agreed Mr A was not a candidate for immediate surgery, but that if his blood count could be improved, there might be a window of opportunity for surgery. Following discussions with the Haematology team, Mr A was given a blood transfusion in preparation for surgery. The Orthopaedic team were also contacted who suggested that a date and time for the operation should be organised.

36. On 19 November 2013, the notes recorded Doctor 4's view that the decision on operating was 'finely balanced' and that the views of the family would be crucial. The discussion with Mrs C was conducted by a junior doctor

(Doctor 8) and Mrs C was noted to be shocked by Mr A's prognosis. A further discussion was held on 21 November 2013 with the family. Mrs C was recorded as asking about Mr A's prognosis without surgery and his likely level of mobility. Doctor 8 noted they (Doctor 8) were not certain of the answers to these questions and they would require further advice on these points. The notes recorded that Doctor 8 informed Mrs C that Mr A's likely survival period without surgery would be 'months'. The Adviser noted it was not clear what the basis for this prognosis was.

37. The Adviser also noted a further discussion on 22 November 2013 between Doctor 8 and the Orthopaedic team. The Orthopaedic team were strongly in favour of an operation if Mr A could be made fit for theatre. The Orthopaedic team's assessment of the implications for Mr A of not carrying out surgery were also documented, including limited likelihood of survival. A discussion was also recorded with the Haematology team, who provided instructions on how to improve Mr A's blood count prior to surgery. Mr A was recorded as 'ambivalent' about the surgery and a note was made to discuss the case further with Mrs C.

38. Doctor 8 recorded a discussion later on 22 November 2013 with Mrs C's husband (Mr C). It was explained that the Orthopaedic team were keen to perform the operation, which would provide benefits in terms of Mr A's on-going care. It was recorded that Mr C thought Mr A would want the operation to take place, if possible. Mr C was noted as agreeing to discuss the matter further and Doctor 8 gave him information on how he could be contacted. The plan was to have a further family meeting at 17:00 that day if the Orthopaedic and Anaesthetic teams were happy to proceed.

39. A further discussion was recorded at 17:30 on 22 November 2013 between Mrs C and Doctor 8. She was told that Orthopaedics considered Mr A a high risk patient, and that the Anaesthetic team had not yet come to a view, but would assess Mr A for theatre the following day. It was recorded that Mrs C was reluctant for Mr A to have the surgery, especially if he remained able to mobilise. The record of the meeting goes on to state 'However, she is amenable to it [the operation] if it must [underlined in manuscript] happen'. It was also noted Mrs C had power of attorney.

40. On 23 November 2013 an acting consultant (Doctor 9) noted Mr A was not experiencing any pain with relatively low doses of pain relief and that the feeling

from the family seemed to be that Mr A should not have surgery. The decision was, therefore, taken to manage Mr A conservatively. The Orthopaedic team were told that Mr A would not be having surgery and it was noted they remained happy to be contacted again if required.

41. On 25 November 2013, Mr A's clinical signs suggested that his pneumonia was advancing and his condition was noted to be deteriorating. He was recorded as 'without pain, but very confused'. Doctor 8 reviewed Mr A with Mrs C present. He was easy to rouse, although drowsy and this was attributed to an excess of morphine having been given. The situation was discussed with Mrs C and Mr C and they were informed Mr A was unlikely to survive more than a matter of days.

42. On 26 November 2013, Mr A was noted to be deteriorating further, with decreasing oxygen saturation (the level of oxygen in his blood). He was given paracetamol to lower his body temperature, an additional antibiotic and his blood transfusion was to be slowed down. At 02:30 Mr A was recorded as having suffering a cardiac arrest and CPR attempted. The attempts at CPR continued for 25 minutes, but were unsuccessful and Mr A died at 02:27. The notes recorded that Mrs C was informed at 02:55.

The Adviser's Conclusions

Mr A's capacity to provide informed consent

43. The Adviser said that although Mr A was 'ambivalent' about surgery there was no evidence Mr A's mental capacity had been assessed[1], with regard to his decision making capability following his admission to hospital. Nor had it been established at an early stage whether Mr A's family held power of attorney for his medical welfare.

The decision on whether a hip operation was appropriate

44. The Adviser also said the default position for a frail elderly patient would be to repair the fracture as soon as possible. It was recognised that the longer this was delayed, the worse the outcome was for the patient in terms of complications and survival.[2,3,4] Failure to repair a hip fracture in an older patient usually resulted in death within days or weeks, often due to pneumonia. The

[1] Mental Capacity Act (2005)
[2] Novak et al. International Journal for Quality in Health Care; Volume 19, issue 3.
[3] NICE Guideline 124; Management of Hip Fracture in Adults (2014)
[4] Care of Patients with Fragility Fracture, British Orthopaedic Society, September 2007

patient would often remain bed bound and they would continue to experience pain.

45. The Adviser also noted that there was a 'window of opportunity' for fixing a hip fracture in a frail or elderly patient, usually as close as possible to the occurrence of the fracture itself. Ideally this would be within 24 to 48 hours of the fracture, once the patient's medical condition had been stabilised.

46. He said in his view, the delay in diagnosing Mr A's hip fracture, meant there was no possibility of using the window of opportunity when repairing his fracture would have had the best chance of a positive outcome. He noted though that Mr A's survival chances would have been small even had an operation been performed.

47. The Adviser was also critical of the lack of consultant led engagement with the family. He said the notes suggested this further delayed the decision whether or not to fix the fracture. The Orthopaedic team were keen to operate as soon as Mr A's platelet count could be corrected and an anaesthetic assessment had been carried out. The Adviser said that by the time Mr A's family had made the decision not to opt for surgery, Mr A was clearly dying and the window of opportunity for surgery had been missed.

48. The Adviser acknowledged that it was reasonable when a patient was clearly approaching the end of their life not to attempt surgery, provided that pain did not then become a major issue for the patient. The Adviser said, however, that an appropriate palliative care plan should have been in place, including consideration of whether Mr A was suitable for resuscitation.

Resuscitation

49. The Adviser was highly critical of the failure to consider designating Mr A as unsuitable for resuscitation, once the decision had been made that his prognosis was poor. He said that it was established best practice for all health boards to have appropriate end of life pathways in place.[5] This allowed families, carers and if appropriate, the patient to be fully informed and involved in the decision making processes. Patients on this treatment pathway should not undergo CPR in the event of cardiac arrest. The Adviser said the attempts

[5] Palliative and End of Life Care for Older People; British Geriatric Society Best Practice Guidelines (2010)

at resuscitation had been futile and represented a final indignity for Mr A. The Adviser said a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order should have been discussed with the family and placed prominently in the front of the case notes.

50. The Adviser said the Board's end of life pathway and DNACPR policies should be reviewed. He said that the attempt to resuscitate Mr A when he was clearly dying was wholly inappropriate and constituted a major failing. The Adviser suggested that a morbidity and mortality case review should be carried out, and used to provide an action plan to prevent a reoccurrence of the failings identified.

Failings acknowledged by the Board

51. The Adviser said that although the Board had acknowledged some failings, they had not identified further failings in Mr A's care that had been overlooked. He said the Board should have clear guidelines in place on the management of patients with neutropenic sepsis. This should include a policy the use and prioritisation of side rooms, to avoid transfer delays. He also said that the Board's guidelines for the use of x-rays following a fall should be reviewed. He said that older patients needed special consideration and that the default position should be to x-ray, given the high risk of hip and pelvic fracture in this patient population. The Adviser added that the Board also needed to provide clear guidance for medical staff on the responsibility for ensuring that test requests were received by the appropriate facility, actioned and reviewed by the requesting doctor. Where this was not possible due to shift changes, then the Board needed to ensure that the appropriate handover took place.[6] The Adviser further noted the Board needed to ensure that adequate handover arrangements were in place when ward patients were reviewed by out-of-hours doctors.

52. The Adviser also said that the Board needed to review their guidance to staff to ensure there was an early assessment and documentation of lasting power of attorney over a patient's medical welfare. Where appropriate, a patient's mental capacity should be assessed and clearly documented. He noted this information was essential to direct timely and appropriate discussions with a patient's family.

[6] Royal College of Physicians Acute Care Toolkit 1: Handover; RCP; 2011

(a) Conclusion

53. The complaint I have investigated is that the Board failed to provide reasonable care and treatment to Mr A. I have received clear advice, which sets out a number of failings in the care and treatment Mr A received.

54. The Adviser has stated that the delay in x-raying Mr A following his fall was unacceptable. Although it is not possible now to state with certainty whether this delay directly affected Mr A's prognosis, the Adviser's view is that it denied Mr A the option of having surgery carried out. I note the Adviser's view is that it would have been reasonable for an urgent x-ray to be requested on 9 November 2013, given Mr A's age and risk of pelvic or hip fracture. I also note the Adviser considered the description of Mr A's symptoms on 10 November 2013 to be a 'classical' sign of hip fracture and that there should have been a high suspicion of a fractured hip, with an appropriately urgent x-ray carried out.

55. Whilst the Board have acknowledged that the optimal point for an x-ray to be carried out would have been 10 November 2013, there is no indication that they have considered the implications of this delay on Mr A's suitability for surgery.

56. By the time the x-ray was carried out, Mr A's condition had deteriorated to a point at which he was not suitable for surgery. I do not agree with the inference in the Board's letter to Mrs C of 30 December 2013 that Mr A was never suitable for surgery, as I note the Adviser has identified in the medical record a clear period when surgery was actively being prepared for by clinical staff.

57. There is also a contradiction inherent in the Board's position on Mr A's care. If Mr A was not a suitable candidate for surgery, due to his prognosis, then he should have been placed on a palliative care pathway. As part of his palliative care, Mr A should have been considered for DNACPR and a discussion initiated with his family, but the Adviser noted there was no evidence of this. The clinical record details a number of discussions with the family about Mr A's care and his suitability for surgery. It is not clear why no attempt was made to discuss Mr A's resuscitation at this point. This meant Mr A was subjected to an extended attempt to resuscitate him, which the Adviser described as futile. The Adviser considered this a major failing, which significantly compromised Mr A's dignity.

58. I further note the Adviser's suggestions for the actions that the Board should now carry out to prevent a reoccurrence of the failings identified. In particular, a morbidity and mortality review should be carried out, in order to identify the appropriate learning from the case.

59. Although I note the Board have already accepted there were failings in Mr A's care and apologised for these, the Adviser has highlighted further significant failings and inconsistencies in the care and treatment provided to Mr A. In view of the failings identified, I consider that the care Mr A received fell below a reasonable standard.

60. I uphold this complaint.

(a) Recommendations

61. I recommend that the Board:	*Completion date*
(i) ensure its policies set out clear responsibilities for clinicians to ensure that tests are either reviewed by the requesting doctor, or handed over to colleagues;	29 April 2015
(ii) carry out a morbidity and mortality case review of Mr A's death. The review should include the actions of the Haematology and Orthopaedic departments and evidence should be provided that the following points were addressed: the handover procedures followed by medical staff to ensure all necessary information regarding patients was transferred appropriately; the care and treatment pathways for the management of patients who fracture their hip whilst on a geriatric ward; the failure to ensure that DNACPR was discussed appropriately with Mr A or his family; whether the Board's end of life and palliative care policies were properly followed; whether Mr A's mental capacity was properly assessed and what procedure should have been followed; review whether there was appropriate and timeous discussion of resuscitation with Mr A's family; review the failure to document in	20 July 2015

	Mr A's medical record the reason for his ward transfer; review the lack of early Consultant input into case discussions with Mr A or his family; and	
(iii)	include the findings of the morbidity and mortality review in the subsequent appraisal of the consultant responsible for Mr A's care.	18 September 2015

(b) The Board did not communicate reasonably with Mr A's family between 25 October and 26 November 2013

62. Mrs C said that she did not feel that staff had communicated reasonably with Mr A's family. She said that they had been ignored when seeking information and they had not been given clear answers to their questions about Mr A's prognosis when discussing his suitability for surgery.

63. Mrs C also complained that Mr A was moved between wards without the family being notified. She also noted that the reason for the transfer between wards was never explained to the family.

The Board's Position

64. The Board said they were sorry Mrs C felt ignored by staff and that she had not been provided with adequate information about Mr A's transfer between wards. The Board said that next of kin would normally be informed of a ward transfer. The Board said the need to keep family informed had been reinforced to ward staff.

Advice Received

65. The Adviser said there was no documentation to explain Mr A's transfer from Ward 50/51 to Ward 18/19. He said it was, therefore, not possible to comment on the appropriateness of the decision to transfer Mr A. The Adviser also noted there was no documentation to show Mr A's family were informed of the transfer, or that they were aware of the reasons behind it.

66. The Adviser said established good practice would be to nurse a patient with neutropenic sepsis in a side room, to reduce the risk of hospital acquired infection. The Adviser noted that Mr A's clinical record indicated on 30 October 2013 that he was in a side room, however on 31 October 2013, the notes stated 'discussed with haematology, should be fine to leave the ward …' He noted the record did not give any indication why Mr A needed to leave the ward. The Adviser said there was no evidence to support the Board's suggestion that Mr A

was transferred on the basis of infection control issues or the availability of side rooms. He said Mr A and his family should have been informed of the reason for the transfer and this should have been clearly recorded in Mr A's notes.

67. The Adviser noted the family had not had the opportunity early in Mr A's admission to discuss his treatment. He said that discussions about the relative risks and benefits of surgery should have been led by a consultant orthogeriatrician. If such a clinician or service was not available, then discussions should have been led by consultants with knowledge and experience of managing hip fractures in frail older people.

68. The Adviser also said the records showed the discussions were largely left to junior members of the medical team. Although these doctors did their best to address the issues raised by the family, there were clear gaps in their knowledge, which required clarification by senior doctors. He said in his view, this delayed the decision making process.

69. The Adviser was also critical of the failure to discuss the possibility of resuscitation with the family. As detailed previously, this led to an unnecessary attempt at resuscitation, which in the Adviser's opinion compromised Mr A's dignity, with little realistic prospect of success.

(b) Conclusion

70. The complaint I have to consider, is whether the standard of communication between the Board and the family could be considered reasonable. I acknowledge that the Board have already accepted that the family should have been informed of the transfer of Mr A from one ward to another. I note, however, the Adviser's comments on the lack of documentation in the clinical record explaining this transfer. This means that although the Board have stated Mr A was transferred in an effort to reduce his risk of hospital acquired infection, there is no evidence to support this.

71. I further note the Adviser's comments on the standard of communication with the family once Mr A had suffered his fall and fractured hip. He has been critical of the failure by senior medical staff to lead in discussions with the family and has pointed to the fact that Mr A's diagnosis had already been delayed by the failure to pursue x-ray imaging timeously. His view was that this further delay was avoidable and compromised Mr A's care. I also note that the Adviser has identified a further consequence of the lack of clear information being

provided to Mr A's family. On 21 November 2013 the family were informed that Mr A's prognosis was 'months' if surgery was not carried out. This information appears to have been inaccurate and gave the family false expectations over Mr A's likely life span whilst receiving palliative care.

72. Additionally, I note that the Board's investigation did not identify the failure to discuss the question of resuscitation with the family. The Adviser has been particularly critical of this, given the outcome for Mr A, which he considered a major failing on the part of the Board. I am critical of the failure of the Board to identify this issue when investigating the matter themselves. Mrs C, as a lay person, would not be aware of this failing, or its significance and the responsibility of the Board to scrutinise its own actions in this regard is, therefore, arguably greater.

73. Overall, given the evidence available and the advice I have received, I consider that the standard of communication with Mrs C and her family fell below the standard they could reasonably have expected.

74. I uphold the complaint.

(b) Recommendation

75. I recommend that the Board:	*Completion date*
(i) remind all staff of the importance of documenting and signing discussions with patients' families.	15 April 2015

(c) The Board did not respond reasonably to Mrs C's complaints about these matters

76. Mrs C had complained to the Board in late November 2013, about Mr A's care and treatment whilst Mr A was still alive. The Board responded on 30 December 2013, after Mr A had died. I note that Mrs C's letter of complaint is undated, although the Board's records would indicate it was received either on or around the 26 November 2013. Mrs C complained about the standard of care Mr A was receiving and highlighted the delays in providing Mr A with appropriate x-rays and the dilemma the family had been placed in, as they were now presented with a high risk operation, or the prospect of allowing Mr A's fractured hip to remain untreated.

77. Mrs C said to my office that she felt the Board had dismissed these complaints. Her impression was that the Board's view was that it was likely

Mr A would have died, regardless of the standard of care he received. Mrs C said she felt the Board had not properly addressed the issues she had raised.

78. The Board's view was that Mrs C's complaint had been thoroughly investigated. The letter produced had considered the majority of complaint elements raised by Mrs C, but had found that although there had been delays, it had not affected the outcome for Mr A. The Board had acknowledged there had been failings and had apologised for them, setting out the action they intended to take in order to avoid a reoccurrence. This included a review of their procedures for requesting x-rays, and reminders to all staff about the importance of accurate and timeous communication with patients and their families.

(c) Conclusion

79. In investigating this complaint, I have considered the timescale of the Board's response. This is of particular significance in this case, since Mr A was still alive at the time of Mrs C's original complaint, which listed significant concerns about Mr A's care and treatment. I note that the Board appear to have received the complaint around 26 November 2013, with it being passed on for investigation on 26 November 2013, the day Mr A died. In the circumstances, therefore, I do not consider the Board had time to investigate the complaint prior to Mr A's death.

80. Although the Board's investigation did identify failings in the care provided to Mr A, I do not consider it was adequate. I have noted previously the failings identified by the Adviser in the medical care provided to Mr A. Although the Board have acknowledged the delays in providing x-rays for Mr A, they have not provided evidence of any changes subsequently made to prevent a reoccurrence. The Board were unable to identify why the request for an x-ray for Mr A took some thirty hours to reach the x-ray department. I do not consider it sufficient, therefore, for the Board to merely state that their systems did not work on that occasion. I note that the Board have stated that they are reviewing their x-ray request protocols following a fall, but no evidence has been provided to support this statement.

81. Overall, although the Board's reply to Mrs C's complaint provided a detailed account of Mr A's care and treatment, their investigation did not identify some significant failings in Mr A's care and treatment. Additionally the Board

have not provided evidence that they have taken action to fully address the failings it has already apologised for.

82. On the basis of the evidence available, I do not consider the Board's investigation of Mrs C's complaint was reasonable.

83. I uphold this complaint

(c) Recommendation

84. I recommend that the Board:	*Completion date*
(i) provide evidence that the actions referred to in the complaint response letter have been implemented.	15 April 2015

General recommendation

85. I recommend that the Board:	*Completion date*
(i) apologise for the failings identified in this report.	15 April 2015

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

Annex 1

Explanation of abbreviations used

Mr A	the complainant's father, whose treatment was the subject of the complaint
MMSE	Mini Mental State Examination
the Hospital	Glasgow Royal Infirmary
Mrs C	The complainant
CPR	cardio-pulmonary resuscitation
DNACPR	do not attempt cardio-pulmonary resuscitation
the Board	Greater Glasgow and Clyde NHS Board
Doctor 1	a junior doctor who reviewed Mr A following his fall on 9 November 2013
Doctor 2	a specialist registrar who reviewed Mr A on 10 November 2013
Doctor 3	a junior doctor who reviewed Mr A on 11 November 2013
Doctor 4	the consultant who reviewed Mr A on 12 November 2013
Doctor 5	the consultant who reviewed Mr A on 17 November 2013
Doctor 6	orthopaedic junior doctor who

	reviewed Mr A on 17 November 2013
Doctor 7	a senior registrar who reviewed Mr A on 18 November 2013
Doctor 8	a junior doctor who discussed Mr A's prognosis on 19 November 2013 with the family
Mr C	Mrs C's husband
Doctor 9	an acting consultant who reviewed Mr A on 23 November 2013

Annex 2

Glossary of terms

anaesthetic	drug causing loss of sensation of consciousness
antibiotic therapy	medicine used to treat infections
beta blocker	drug used to reduce heart rate
bone marrow	tissue within bones which produces blood cells
cardiac arrest	heart failure, causing effective blood circulation to cease
cardio-pulmonary resuscitation (CPR)	emergency procedure to maintain blood flow, to allow measures to be taken to restore unaided blood circulation
cognitive abilities	mental process, including attention span, memory, knowledge and ability to form rational judgements
Do not attempt cardio-pulmonary resuscitation (DNACPR)	form indicating to medical and nursing staff that CPR should not be attempted
fracture	a break to a bone
haematology	medicine concerned with the study, diagnosis, treatment and prevention of diseases relating to the blood
impacted fracture	bone break, where the broken ends are wedged together

Mini Mental State Examination (MMSE)	test used to diagnose and assess dementia
myelodysplasia	a blood disorder causing a drop in the number of healthy blood cells
neutropenic sepsis	fever along with other signs of infection in a patient with a low white cell blood count
orthopaedics	medicine concerned with conditions involving the skeletal system
palliative care	care aimed at relief of symptoms, primarily pain for seriously ill patients
pneumonia	infection causing inflammation of the lung
white blood cells	blood cells which help protect the body against disease
x-ray	imaging technique, using radiation to view the interior of the body

Annex 3

List of legislation and policies considered

The Care of Patients with Fragility Fractures; British Orthopaedic Association; September 2007; 2.2 falls assessment and diagnosis; page 14

Palliative and End of Life Care for Older People; British Geriatric Society Best Practice Guidelines (2010)

Royal College of Physicians Acute Care Toolkit 1: Handover; RCP; 2011

Mental Capacity Act (2005)

Novak et al. International Journal for Quality in Health Care; Volume 19, issue 3;

NICE Guideline 124; Management of Hip Fracture in Adults (2014)

Care of Patients with Fragility Fracture, British Orthopaedic Society, September 2007