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: Highlands and Islands

Case ref: 201404874, Highland NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Mrs A had a form of dementia and was being looked after at home by her family. When the family became unable to care for her at home, she was admitted to New Craigs Hospital, with the aim of assessing her mental health and finding appropriate medication to enable her to return home. Following falls in hospital, however, Mrs A's physical health deteriorated. She was transferred to Raigmore Hospital, where she was found to have a fractured pelvis and urine retention. Her daughter (Mrs C) made complaints about the admission process and the care and treatment Mrs A received at New Craigs Hospital.

As part of my investigation, I obtained independent advice from a psychiatric nurse, a psychiatrist and an elderly medicine specialist. Mrs C complained that the board should have admitted Mrs A to hospital for mental health assessment earlier. I was critical that, from the evidence available, the community mental health team did not provide enough information and advice about the waiting list and what to do if the situation deteriorated. However, the advice I received was that keeping Mrs A at home whilst waiting for a hospital bed was reasonable in the circumstances. I did not uphold this complaint.

Mrs C complained about various aspects of the nursing care provided to Mrs A in New Craigs Hospital. She was particularly concerned about the assessments of falls risk and of Mrs A's pain, the lack of referrals to doctors, the poor monitoring of Mrs A on the ward, and the use of a wheelchair to transfer Mrs A for an x-ray. The psychiatric nurse adviser was very critical of the nursing care Mrs A received, and concluded that it was disorganised, unsystematic and unreasonable. They noted the lack of a nursing care plan, poor evidence of falls assessments, and no evidence of proper monitoring of Mrs A's pain. The psychiatric nurse adviser found that nursing staff failed to bring Mrs A's first fall to the attention of medical staff until a day and a half later, despite clear evidence of bruising and changes in Mrs A's behaviour. They also commented that it was inappropriate to transport Mrs A in a wheelchair when it was suspected that she had a pelvic fracture. The advice I received clearly shows that Mrs A did not receive reasonable nursing care. In particular, I was

concerned that nursing staff did not identify changes in Mrs A's behaviour, assess her falls risk, monitor her pain, or ensure that doctors were aware of the situation, even though Mrs C was raising concerns. I upheld this complaint and recommended an internal review to identify changes.

Mrs C complained about several aspects of Mrs A's clinical treatment, including the way medical staff considered the evidence of her deterioration, and that not enough account was taken of her changing behaviour. She asked whether more scans should have been taken to investigate Mrs A's pain. Overall, Mrs C felt that Mrs A should have been transferred to a medical ward much sooner. The advisers noted that, on admission, Mrs A was mobile and active but, within 48 hours, she was in obvious pain and unable to bear weight. It is clear to me that when x-rays did not identify a fracture, doctors did not do enough to consider what was causing the pain, or causing changes in Mrs A's behaviour and continence. Additionally, I was concerned that doctors did not do enough to relieve her pain. I upheld this complaint.

Mrs C also raised concerns about the record-keeping of the board, particularly with regards to Mrs A's food and fluid intake, falls assessments, the use of hip protectors, and Mrs A's level of consciousness. My psychiatric nurse adviser found that, for all of these areas, the record-keeping was poor. Additionally, they were critical that there was no overall care plan so important issues were likely to be neglected, and that record-keeping was mostly retrospective. It was my opinion that poor record-keeping of Mrs A's care went hand-in-hand with poor care planning and provision, and both were well below reasonable standards. I upheld this complaint.

I also upheld Mrs C's complaint about the board's response to her complaint about Mrs A's care and treatment. I found that the response did not fully respond to Mrs C's questions, was overly defensive and lacking in empathy.

Redress and recommendations

The Ombudsman recommends that the board:	*Completion date*
(i) conduct a Significant Event Analysis, aimed at exploring and understanding the causes of the care failures for Mrs A, in order to identify appropriate improvements in clinical practice; and	16 March 2016
(ii) apologise to Mrs C for the failings identified in this	20 January 2016

report, both in relation to Mrs A's care and treatment and in relation to the response Mrs C received to her complaints.

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 the aggrieved is her mother, Mrs A. 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 the SPSO about the care and treatment her mother (Mrs A) received from New Craigs Hospital (Hospital 1) in February 2014. The complaints from Mrs C which I have investigated are that Highland NHS Board (the Board):

(a) unreasonably failed to admit Mrs A to hospital at an earlier stage for mental health assessment (*not upheld*);
(b) failed to provide Mrs A with an appropriate level of nursing care (*upheld*);
(c) failed to provide Mrs A with appropriate clinical treatment for the symptoms which she presented with (*upheld*);
(d) failed to keep accurate and comprehensive clinical and nursing records (*upheld*); and
(e) failed to provide a reasonable response to Mrs C's complaint about Mrs A's care and treatment (*upheld).*

2. Mrs A, who suffered from a form of dementia, was being looked after at home by her family. When the family became unable to care for her at home, she was admitted to Hospital 1, with the aim of assessing her dementia and finding appropriate medication for her, to enable her to return home. However, Mrs A's physical health deteriorated while she was in Hospital 1, following two falls, and she was transferred to Raigmore Hospital (Hospital 2), where she was found to have a fractured pelvis and urine retention.

Investigation

3. In order to investigate Mrs C's complaint, my complaints reviewer sought independent advice from a psychiatric nurse (Adviser 1), a psychiatrist (Adviser 2) and an elderly medicine specialist (Adviser 3). In this case, we have decided to issue a public report on Mrs C's complaint because of the significant personal injustice Mrs A suffered while in Hospital 1, and because of the systematic nature of the failings, with a lack of coordination between staff in planning for and responding to Mrs A's care needs.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Key Events

5. Mrs A was living at home, with live in assistance from two people, and was waiting for a bed to be available at Hospital 1 for an in-patient assessment and

review of her medication. Mrs A was under the care of the community mental health service, and Mrs C was in regular contact with community psychiatric nurses from 27 January to 11 February 2014. Her daughter, Mrs C, was very involved with Mrs A's care, and brought this complaint to us. She reported that her mother's condition was deteriorating and her behaviour was becoming increasingly difficult to manage at home. She was agitated and, at times, was trying to leave the house and was becoming increasingly physically aggressive. In a call to the team on 10 February 2014 Mrs C said she was having significant difficulty keeping Mrs A safe at home.

6. On 11 February 2014 a locum psychiatrist (Doctor 1) visited Mrs A at home. He reviewed Mrs A's medication. Mrs C was told that an urgent home visit could be arranged if there was a further deterioration in Mrs A's condition. Mrs C has also reported that she was in touch with Doctor 1 around this time, requesting admission for Mrs A, but that she was told a bed was available, but that it was being 'withheld'.

7. Over the next few days, circumstances changed at home and Mrs A's behaviour became unmanageable. She was seen by a GP at the Out of Hours service at Hospital 2 on 15 February 2014 and they arranged for her to be transferred immediately and admitted to Hospital 1.

8. During the admission process Mrs A was noted as being at high risk of falls. That evening, she showed signs of being agitated and unsettled. She spent much of the night in the lounge, where she was seen rearranging furniture.

9. The next day Mrs A was seen by a consultant (Doctor 2), who reviewed her and noted her diagnosis of Lewy Body Dementia. He noted that she had been up all night, and that she sometimes grabbed and kicked out. She was noted to be able to get up on her own and had been walking around. Doctor 2 noted that nursing staff were to consider a risk assessment and management plans to prevent falls.

10. Nursing notes indicated that for much of that day Mrs A was unsettled and was at times uncooperative, physically and verbally abusive towards staff. The notes indicated that she was wearing hip protectors (a padded band positioned around the hips, designed to absorb and deflect impact away from the hip bone during a fall) during the afternoon.

11. At around 01:00 on 17 February 2014 she was found on the floor of her bedroom, sitting behind the door. She said she had fallen. Nursing notes indicated that staff checked her over, and that she was in the lounge for a while before settling to sleep at about 02:00. (This is in contrast to a record of her sleeping pattern, which indicated that she was asleep from 12:00 to 07:00.)

12. Mrs A was reviewed by Doctor 1 on 17 February 2014, but the notes did not indicate any discussion of her fall.

13. During a telephone call with Mrs C's sister that day, the staff checked whether Mrs A would be able to report pain if appropriate. They were reassured that she would. Mrs C's sister was also informed that staff would be using hip protectors and a bed alarm as precautionary measures. Mrs A's family visited her for long periods every day, and have questioned whether she ever wore hip protectors as they never saw them on or near her. They have also reported that a bed alarm was never installed.

14. That afternoon nursing staff noted that Mrs A was in 'obvious discomfort' and they tried to identify where her pain was coming from. Through the afternoon there was a deterioration in Mrs A's mobility, and by the evening nursing notes indicated that she was unable to weight bear. She was also noted to have small bruises on her right hip and left buttock.

15. The next day (18 February 2014) Mrs A was seen by a junior doctor (Doctor 3) following her fall in the early hours of the previous day, and at Mrs C's request. Doctor 3 noted that Mrs C and her sister were concerned about changes they had seen in Mrs A's behaviour which were out of character, and said this should be investigated further. They noted that she was not communicating and had a minimal range of movement. Doctor 3 noted that she was tender over her sacrum and hips, and they needed to rule out the possibility of a fracture.

16. Mrs A was taken to Hospital 2 via the ward mini bus, in a wheelchair. Mrs C has reported that Mrs A was in obvious pain during the journey there and back again. Once there, she had four x-rays of her right hip and pelvis, but these did not identify any injury or fracture. At Accident and Emergency (A&E) Mrs A was reviewed by a senior doctor (Doctor 4), who reviewed her x-rays and her physical condition, and was satisfied that Mrs A had not broken a bone.

Doctor 4 noted that abnormalities in her urine had been found by staff in Hospital 1, and prescribed antibiotics for a suspected urine infection.

17. Subsequent nursing notes indicated that Mrs A was assisted with basic care needs, due to her lack of mobility. The notes identified restlessness and agitation, and at times noted that she was uncooperative when staff were helping her, including punching, kicking and pinching. They reported that she was clenching her hands and closing her eyes during transfers, but did not note any pain. Mrs A's suspected urinary tract infection was noted as a possible cause for her distress, to be investigated further.

18. When Mrs C visited on 20 February 2014, she was upset at finding that Mrs A was asleep in a wheelchair in the lounge, which was noisy at the time. She felt Mrs A was too unwell to be in a social situation, and that she should have been in a peaceful, private area and allowed to rest in bed, as she felt Mrs A was showing clear signs of being unwell and in severe pain. She discussed Mrs A's care with nursing staff, who noted her concerns. The nursing notes indicated that Mrs C was told that 'hipshields would be necessary', and that 'family were happy to purchase hipshields'. Mrs C has said that nursing staff were clear that they would order them; Mrs C said she offered to bring some from home, but the offer was declined. The notes also indicated that a urine test indicated that Mrs A may have a urinary tract infection.

19. On the evening of 20 February 2014, staff found that Mrs A had fallen in her room and had cut her nose and bruised her forehead. Mrs C returned to the ward and was upset to find that Mrs A was again in a busy room with other patients and visitors. Mrs C has reported that Mrs A was having observations taken by a doctor, and Mrs C felt this was inappropriate; she was concerned that Mrs A was in shock from a fall, she had facial injuries, and was not well enough to be in a social situation. Again, she discussed this with staff and insisted that Mrs A returned to her room. From this time, Mrs A was put on 'constant observation' and every half hour nurses noted how and where she was.

20. Mrs A's medical notes included a Patient Moving and Handling Assessment Form (which refers to Mrs A as being unable to walk and requiring a hoist), a Morse Falls Score (a measure of the risk of a patient suffering a fall) (which noted that she needed nursing assistance and no walking aid), and a Falls Prevention Care Plan (which identified that Mrs A needed constant

observation). These care plans were all undated, so it is not clear whether they were developed following her second fall, or earlier in her stay at Hospital 1.

21. On 21 February 2014 Mrs A was reviewed by Doctor 1. He noted recent episodes of aggressive behaviour, that she was unsettled and 'appears to be in some discomfort'. He also noted 'no recent falls'. The plan following this review included constant observations when Mrs A was awake, but for this to be reduced when she was asleep 'at staff discretion'. It was also noted that a high/ low bed was needed to prevent falls. She was also to be encouraged to take more fluids, and that if she drank less than 700 millilitres a further 500 millilitres of subcutaneous fluid (injected under the skin) should be given overnight. Mrs C said staff only responded to concerns over Mrs A's fluid consumption because of concerns she raised with staff. She said they were not effectively monitoring fluid intake. Mrs A's medical notes refer to a fluid chart on 22 and 23 February 2014, though there was no chart available in the records given to us.

22. Mrs C and her sister again met with one of the nursing team, and passed on further concerns about the care Mrs A was receiving. In particular, they were concerned that the x-rays had not picked up a fracture and asked for them to be reviewed. The duty doctor was contacted, and asked to review Mrs A's x-rays. That evening Mrs A's care was also reviewed by her consultant (Doctor 5). He maintained Doctor 1's plan, and noted the need for adequate pain control and reassurance. However, Mrs C has reported that, despite this reassurance, the family did not have any confidence in the staff's ability to care appropriately for Mrs A.

23. Nursing staff recorded that Mrs A was given 500 millilitres of subcutaneous fluid overnight on the night of 21 February to 22 February 2014, though Mrs C has disputed whether this happened.

24. Around this time, nursing notes indicated that Mrs A frequently had her eyes closed, and often did not talk. When she was being moved she sometimes clenched her fists, or pinched at herself or others around her. She also called out when being moved. When she was seated she sometimes kicked out at staff. At other times she was noted to be settled in bed or asleep.

25. Mrs A's notes indicated that Mrs C again expressed concerns about Mrs A's deteriorating condition on Saturday, 22 February 2014, and requested

that she be seen by a doctor. The on-call doctor, a GP trainee doctor (Doctor 6) reviewed her. Doctor 6 noted that the x-rays had not found a fracture of Mrs A's right hip (though the notes suggest that Doctor 6 was under the impression that Mrs A had been x-rayed since her last fall). They also noted that they were unable to access the x-rays on their systems.

26. Doctor 6 reviewed Mrs A's condition and noted that, while she did not appear to have any bony tenderness, she was distressed by being moved in bed. Doctor 6 also noted persistent bruising on Mrs A's right hip and buttock and on both her legs. She ordered further blood tests. Mrs C has reported that this was in response to her concerns about Mrs A's overall condition and fluid intake, and that she had to take the sample to Hospital 2 for analysis because this service was not available at Hospital 1 at weekends. They were received by Hospital 2 at 20:10 that evening.

27. That day nursing staff also noted that Mrs A's condition had not improved, despite medication for a potential urine infection. She was also restless in bed and was, at times, unwilling to take her medication. It was also noted that she only seemed to urinate when in an upright or standing position when assisted.

28. Doctor 6 reviewed Mrs A again the next day, and noted little change in her condition, other than increased bruising on her right leg and pain and distress on moving that leg. However, it was again noted that an x-ray had shown that Mrs A's hip was not fractured. Mrs A's pain killers were increased and further effort was made to ensure she was kept hydrated, as the blood tests indicated Mrs A had mild dehydration.

29. That day, nursing staff again noted that Mrs A was clenching her fists and keeping her eyes closed. They also noted that she was holding her head very stiffly.

30. On 24 February 2014 nursing staff made contact with a consultant (Doctor 7) from Hospital 2, who was asked to review Mrs A. It was noted that this was not possible until the following day. That evening she was reviewed by the duty doctor, a junior doctor (Doctor 8), who noted that Mrs A seemed to be in physical pain but Doctor 8 could not identify the source of the pain. The medical records indicated that Doctor 8 did not identify any abdominal tenderness or pain around Mrs A's hips or pelvis and noted that the pain appeared to be sporadic. However, Mrs C has reported that Mrs A was

uncommunicative and delirious during this examination, but that Doctor 8 did not take account of this. During discussions with Mrs C, it was acknowledged that further investigation at Hospital 2 was necessary and that further plans would be made for this the following day. The plan for overnight was to keep Mrs A as comfortable as possible and to start her on broad spectrum antibiotics and antispasmodic medication.

31. Doctor 1 also reviewed Mrs A's care that evening, and noted the family's concern about her pain and deterioration. He noted that Mrs C was 'pleased with current nursing care', but wanted an earlier referral to Hospital 2. He reassured Mrs C that Mrs A would be reviewed by Doctor 7 the next day, when plans would be made for further investigation. However, Mrs C has reported that she was not happy with the nursing care, but was relieved that Mrs A was receiving appropriate medication and was more settled. She was also relieved that they were taking Mrs A's condition seriously, and that there was a plan to transfer her the next day.

32. When Doctor 7 saw Mrs A the next day, he noted that her eyes were closed, that she was not speaking and her neck was extended. He also noted that she had fallen on 17 February (and had not been weight bearing since), and again on 20 February. His initial impression was that she had delirium, though he was not clear on the cause of this, and whether it was related to her falls or another source.

33. Following this consultation Mrs A was discharged from Hospital 1, and transferred to Hospital 2, where she was found to have a fracture in her left public ramus (a pelvic fracture). She was also found to be in urine retention. She was tested for a range of infections, because it was unclear whether she had any infections that were causing her delirium and her overall deterioration. While no infections were confirmed, a computerised tomography scan (CT scan, using x-rays and a computer to create detailed images of the inside of the body) identified changes in her brain association with a deterioration due to dementia. Mrs A's condition continued to deteriorate, and she passed away on 13 April 2014 at Hospital 2.

(a) The Board unreasonably failed to admit Mrs A to hospital at an earlier stage for mental health assessment

Concerns raised by Mrs C

34. Mrs C has complained about the availability of a bed in the appropriate ward in Hospital 1 for Mrs A. She said that, prior to Mrs A's admission to Hospital 1, she had been trying to get Mrs A admitted, but was repeatedly told that there was no bed available in the appropriate ward and that she was on a waiting list. However, when the family reached a crisis point, a bed became available. She has complained that the family had not felt able to care for Mrs A appropriately at home for some time, and had been concerned about her safety and their own. They raised these concerns repeatedly with staff in the days before her admission, and complained that a bed should have been made available to Mrs A earlier.

The Board's response

35. In their response letter to Mrs C, the Board said that Mrs A was admitted when a bed was available in the appropriate ward, and at the point that it was felt clinically appropriate. The Board made nor further comments about this complaint during our investigation.

Medical advice

36. We sought advice from a psychiatric nursing adviser (Adviser 1) and a psychiatric adviser (Adviser 2) in relation to this complaint. Adviser 1 noted that it was not clear when a bed had become available on the ward, so it was not possible to say whether Mrs A could have been admitted to Hospital 1 earlier than she was. However, he said that, in view of the fact that the family were known to be struggling, he would have expected to see more recorded evidence of on-going communication with the family and forward planning to cover potential crises which might occur out-of-hours.

37. Adviser 2 noted that Mrs A had been diagnosed with a neuro-psychiatric disorder prior to admission, but the exact nature of the condition had not been clarified. He also noted that various medications had been tried at home. He was satisfied that the level of contact and advice given in the community were reasonable, and that attempts to maintain Mrs A at home as she waited for a planned assessment were reasonable. He also noted that it is usual for some services to maintain one or more empty beds to cope with emergency situations while still maintaining a waiting list for planned or elective admissions.

(a) Decision

38. The period prior to Mrs A's admission to hospital was clearly a very difficult time for Mrs C and her family, and they were struggling to keep Mrs A safe at home as her condition deteriorated. I can, therefore, understand their concern that a bed seemed to have 'become available' when their situation could be considered an emergency and not before.

39. However, from the advice I have received, based on the records available, I am satisfied that the assessment to keep Mrs A at home awaiting a planned admission to hospital was reasonable, given her clinical presentation. When her condition deteriorated further, it was appropriate to reassess her needs and, again, the advice I have is that it was reasonable to admit her as an emergency, given the circumstances at that time.

40. I am, however, critical that the community mental health team did not provide Mrs C and her family with further information and advice about what to do should the situation deteriorate further. It would also have been helpful for them to have had greater clarity about the waiting list and likely timescales. However, I am satisfied that reasonable decisions were made to put Mrs A on a waiting list for a planned admission and then, when the situation deteriorated, for Mrs A to have been admitted as an emergency. I, therefore, do not uphold this complaint.

(b) The Board failed to provide Mrs A with an appropriate level of nursing care

Concerns raised by Mrs C

41. Mrs C has raised a range of concerns about the nursing care that her mother received in Hospital 1. However, these generally focused around key elements of her care, including:

- assessment of falls and the associated use of hip protectors;
- assessment of Mrs A's pain;
- lack of referrals to doctors when symptoms did not improve;
- lack of appropriate arrangements for monitoring Mrs A on the ward; and
- transferring Mrs A to Hospital 2 for an x-ray of a potentially broken hip in a wheelchair.

The Board's response

42. The Board told Mrs C in their response to her complaint that Mrs A had a falls risk assessment completed and hip protectors in place the day after her admission to Hospital 1.

43. In relation to the transport for x-ray, the Board reported that, at the time, the only option available to Mrs A was for her to be transferred in the ward mini bus, by wheelchair, as no alternative transport was available. They said that this was discussed with Mrs C. They reported that it was agreed that Mrs A should use the ward mini bus, rather than delay the x-ray by waiting for an ambulance to be available. They also noted that transferring Mrs A in a wheelchair meant that transfers could be minimised.

44. The Board clarified that Mrs A had sustained two falls while in Hospital 1 and that after the second fall she had a nurse with her at all times. They apologised for the fact that, after this fall, she had observations taken by staff while she was in the day room, with no privacy.

45. The Board also apologised for a lack of monitoring of Mrs A's fluid intake, until this was explicitly requested by Mrs C.

46. Mrs C complained that nursing staff were impatient with her when she requested that her mother be seen by a doctor during the weekend. The Board said that the nurse involved apologised if she came across as irritated, that this had never been her intention. She said that she had been irritated at her colleague who she felt had raised unrealistic expectations in Mrs C that Mrs A's condition would have improved by then.

47. At the end of their response to Mrs C's complaint, the Board apologised that 'the service provided to [Mrs A] did not meet the standards that you might reasonably have expected'. They said they had taken learning points from this complaint, though there was no clear information about what these were.

48. The Board did not provide any further comment to us on this complaint during our investigation.

Policy and Guidance

49. The National Institute for Health and Care Excellence has produced guidelines for the Assessment and Prevention of Falls in Older People (2013),

which is applicable in Scotland. These guidelines specify that all patients aged 65 and over should be considered to be at risk of falling during a stay in hospital. The patient's environment should be assessed and consideration should be given to the need to undertake a 'multifactorial assessment' and a 'multifactorial intervention'.

50. This assessment should identify the patient's risk of falling, through consideration of a range of issues; including cognitive impairment, continence problems, falls history, health problems which may increase the risk of falling, medication and mobility or balance problems.

51. A multifactorial intervention should address the patients' risk factors, and take into account whether these risks can be treated, improved or managed.

52. These guidelines also specified a number of interventions that could not be recommended because of insufficient evidence. This included the use of hip protectors, because trials of their use have been unable to provide evidence that they are effective at preventing fractures.

53. The National Guidelines for the Assessment of Pain in Older Adults (Royal College of Physicians, 2007) set out expectations for care in a range of circumstances. It stated that 'in people with very severe [cognitive] impairment, and in situations where procedures might cause pain, an observational assessment of pain behaviour is additionally required'. These guidelines went on to say that 'pain behaviours differ between individuals, so assessment should include insights from familiar carers and family members to interpret the meaning of their behaviours'.

Medical advice

54. Adviser 1 provided detailed advice in relation to Mrs A's nursing care. He reviewed the care she had been given, and the concerns that Mrs C raised with us.

55. Adviser 1 reviewed the need for care to be planned, following a health assessment, so it can be organised around individual patient needs. He highlighted that there was no specific document outlining a plan of care and that, without this, important issues were likely to be neglected. They explained that care planning provides a 'road map' to guide care providers, and it should

provide a clear account of planned future care, centred around the person's needs.

56. Adviser 1 said they could not find a nursing care plan, and a multi-disciplinary care plan had been left blank. They found no plan for nursing interventions based on agreed aims following an assessment process. Based on this finding, Adviser 1 concluded that Mrs A's care was disorganised, unsystematic and unreasonable.

57. Specifically in relation to assessments of Mrs A's risk of falls, Adviser 1 noted the Morse Falls Scale was completed, and identified that Mrs A was at a high risk of falls. They also noted that the Falls Prevention Care Plan prescribed constant observation and 'hipshields' among other prevention measures. However, they noted that neither of these had been dated, and the lack of dating meant that it could not be determined whether this care plan had been appropriately implemented; it therefore made them ineffectual as evidence.

58. Adviser 1 noted that Mrs A had been identified as being at risk of falls when she was admitted to Hospital 1; it was noted in her Assessment / Admission Document. They also commented that nursing staff often found Mrs A to be drowsy, and said that the need to complete a falls assessment and management plan was indicated by medical staff on the afternoon of 16 February.

59. Adviser 1 went on to say that a falls assessment should have been completed within 24 hours of Mrs A's admission and that it should have been reviewed within seven days. Given that Mrs A was in Hospital 1 for nine nights, they noted that either one or the other of these expectations was not met. Furthermore, they noted that Mrs A's condition deteriorated; her behaviours became increasingly out of character; and she had two falls during her stay. These factors and changes in her presentation should, they said, have prompted a further evaluation of her falls risk, but there was no evidence of this being reviewed.

60. Adviser 1 also reviewed the times when hip protectors were referred to in Mrs A's nursing notes, both in relation to their use and the need to use them. They noted the contradictions between these records and said that there was no indication of their use being evaluated as he considered it should have been.

61. Adviser 1 went on to say that, while hip protectors are often used in hospitals, the evidence in relation to the efficacy of their use is mixed, with no clear evidence to support their use. However, in Mrs A's case, it was not clear when they were put into use, or if they were used consistently. They concluded that both nursing practice and record-keeping in relation to falls assessment and prevention were below a reasonable standard, and this meant that the evidence of whether hip protectors were used appropriately was ambiguous, which was also unreasonable.

62. In relation to the assessment of Mrs A's pain, Adviser 1 commented that changes in a person's ability to communicate verbally present particular difficulties in treating pain, as it is best practice to base any assessment around self-reporting of pain. However, untreated pain could have several consequences; including delayed healing, disturbed sleep and activity patterns, and reduced function. They clarified further that if a patient is unable to report pain, then an observational approach should be taken. This involves an assessment against behavioural factors such as vocalisation, facial expression, body language, behavioural changes and physical changes.

63. Adviser 1 referred to the expectations of national guidelines for the assessment of pain in older adults (Royal College of Physicians, 2007). He noted the need for observational assessment of pain behaviour and to include family members in interpreting the meaning of this behaviour. They found that there was no evidence to demonstrate that Mrs A's pain was systematically monitored or charted and said that this was unreasonable.

64. Adviser 1 went on to review the evidence in relation to Mrs A's referrals to medical staff. They noted that the nursing records indicated that she had a fall in the early hours of 17 February 2014; however, they noted that there was no reference to an incident report, which should have been completed. There was also no evidence that medical staff were made aware of the fall at the ward review meeting that afternoon.

65. Adviser 1 noted that Mrs A's records indicated that there were changes in her behaviour after this time, including resistiveness, reduced appetite, deterioration in communication ability, discomfort and pain on weight-bearing. They went on to say that at 21:55 that evening Mrs A was noted to have bruises on her upper left hip and left buttock, though nursing staff did not appear to

have brought these issues to the attention of medical staff, even when she was being reviewed by Doctor 1 the following day (18 February 2014). Adviser 1 noted that the first reference to the fall by medical staff was later that afternoon, when Doctor 3 saw her, though the record stated 'asked to see patient – fell earlier today', though the fall took place at least 33 hours earlier.

66. Adviser 1 concluded that nursing staff should have brought the fall to the attention of medical staff immediately and the event should have been recorded in the formal incident reporting system. They found that the failure to bring this fall to the attention of medical staff until a day and a half after it took place was unreasonable, especially in light of the clear evidence of bruising and changes in Mrs A's presentation and behaviour.

67. In relation to concerns over the way Mrs A was transported to hospital for her x-ray on 18 February 2014, Adviser 1 noted that Mrs A was going to A&E for an x-ray to rule out a pelvic or neck-of-femur fracture. They considered that if a fracture of this nature was suspected, it would have been important to minimise movement to prevent further damage and complications until the suspicion of facture was ruled out. Under these circumstances, they said that transport in a wheelchair was inappropriate.

68. Overall, Adviser 1 found that Mrs A's nursing care was not systematically planned. They considered that, because of this, Mrs A's care lacked direction and continuity and ultimately contributed to her decline. They found that her deteriorating behaviours were too readily attributed to her dementia and insufficient regard was given to potential physical causes, most notably pain.

69. Adviser 1 noted failures relating to ineffective team-working, infective care-planning, record-keeping errors , ineffective falls prevention practice, ineffective pain management and failure to timeously report a fall to medical staff. They considered that the best way to ensure that these failures of practice were addressed was for the Board to carry out a detailed significant incident analysis to explore and understand the causes of these failures, and address them.

(b) Decision

70. Adviser 1 was very critical of nursing staff in his review of Mrs A's care. In particular, I note their concerns around poor care planning, falls prevention, pain management and referrals to medical staff. It is clear from the advice I have had that Mrs A was not given reasonable nursing care. In particular I am

concerned that nursing staff did not identify changes in Mrs A's behaviour, monitor her pain, or ensure that doctors were aware of the situation, even though Mrs C was raising concerns.

71. The lack of an overall care plan meant that changes in Mrs A's condition were not appropriately considered. She was admitted for assessment of her behaviour relating to her dementia, and to identify appropriate medication for her. However, this assessment was never given any real consideration, as her care needs changed, and yet this does not appear to have been identified as an issue by staff at the time.

72. The lack of appropriate falls risk assessments is of particular concern, given the fall Mrs A had shortly after admission, and the subsequent change in her risk of falls when her mobility changed. It appears likely that the undated Morse Falls Scale and Falls Prevention Care Plan were completed shortly after Mrs A's second fall, as they note the need for constant observation. However, by this time her mobility had deteriorated and she had already fallen twice, with injuries to her pelvis and face.

73. In relation to Mrs A's transport to Hospital 2 for an x-ray on 18 February 2014, it is not clear what was discussed with Mrs C at the time. The notes do not refer to any discussion, and Mrs C's account varies from the Board's account of what happened. Mrs C has reported that she did not feel Mrs A had the choice of an ambulance, though the Board subsequently said that this would have been possible if they had waited for a non-emergency ambulance. It is also not clear how long this wait was expected to be. Given that Mrs A had fallen over 36 hours prior to this, and her condition had changed substantially over this time, I am critical that staff did not do more to try and ensure that Mrs A was transported appropriately.

74. It is clear that, without the failures in nursing care, Mrs A's could have been spared significant discomfort if she had been given appropriate care. I uphold this complaint and I am making a recommendation for a non-judgemental internal review to identify changes which will help to ensure that these failures do not happen again.

(b) Recommendation

75. I recommend that the Board: *Completion date*

(i)	conduct a Significant Event Analysis, aimed at exploring and understanding the causes of the care failures for Mrs A, in order to identify appropriate improvements in clinical practice.	16 March 2016

(c) The Board failed to provide Mrs A with appropriate clinical treatment for the symptoms which she presented with

Concerns raised by Mrs C

76. Mrs C raised concerns about several elements of Mrs A's clinical treatment. She was unhappy with the way medical staff considered the evidence of Mrs A's deterioration; particularly in relation to her pain, bruising, a urine infection, changes in her continence, changes in her mobility and her assessment when she developed neck stiffness. She also raised concerns about whether further scans should have been carried out to identify the source of Mrs A's pain. In particular, she wanted to know why only Mrs A's hip was x-rayed, and not her pelvis and spine as well.

77. Mrs C raised concerns that staff did not take sufficient account of Mrs A's changing behaviour and try to establish what had caused this. In particular, she was concerned about whether two assessments by doctors on 21 February were appropriate, after Mrs A's second fall. She said that these doctors should have questioned why Mrs A's condition had deteriorated so rapidly, rather than simply providing pain relief. She felt doctors should have had clear plans for investigating what was going on and what could be done to avoid further deterioration. Overall, Mrs C felt that Mrs A should have been transferred to a medical ward much sooner.

The Board's response

78. Much of the Board's response to Mrs C's complaints about clinical treatment referred to staff making clinical judgements about what was appropriate, without significant further explanation. This was the response given in relation to her incontinence, stiffness in her neck, and in relation to scans after her falls (more specifically, when an x-ray should have been sought after Mrs A's first fall; and whether further scans would have been appropriate after her second fall).

79. In relation to the assessment made of Mrs A by Doctor 4 at A&E, the Board gave a full explanation of the assessment and why it had not been considered necessary to take further x-rays. They noted that staff from

Hospital 1 had requested x-rays of the pelvis and right hip, which showed no sign of a fracture, and that had been confirmed by a consultant radiologist.

Medical advice

80. Adviser 2 reviewed the care and treatment given to Mrs A while she was in Hospital 1. They considered her assessments by doctors on the ward. In relation to the assessments Mrs A had after her first fall, Adviser 2 found that, while doctors noted the pattern and degree of bruising, they did not adequately consider its clinical significance in relation to a potential bony injury. While there was a reference in the notes that family said Mrs A could reliably indicate if she was in pain or discomfort, Adviser 2 said there was no systematic recording of enquiry or observation of the adequacy of pain control. He considered this to be inadequate.

81. In relation to pain relief, Adviser 2 noted that Mrs A was given simple pain killers, but that the effect and adequacy was not observed or documented. He considered that it was likely to have been insufficient for a bony injury.

82. Adviser 2 commented that Mrs A's change in mobility was linked closely in time with the fall. They noted that simple bruising with adequate pain relief should not have been taken as sufficient explanation without further consideration of other possibilities.

83. Adviser 2 also commented on the changes in Mrs A's behaviour after her first fall; that she was much quieter, had started plucking at her skin and nipping herself. They said that, while the changes in Mrs A's behaviour were noted at the time, they were not adequately considered, and their significance as a sign of deterioration was not identified.

84. Adviser 2 considered the change in Mrs A's continence, and the change to her urinating only when standing. They found that the onset of incontinence and its pattern, particularly after a major fall, was not adequately considered. They also felt there was an over-reliance on Mrs A's apparent urine infection.

85. In addition to the care and treatment given to Mrs A in Hospital 1, I sought advice from Adviser 3 in relation to the x-rays taken at A&E in Hospital 2. Adviser 3 sought to clarify that the x-rays taken on 18 February 2014 included images of Mrs A's hips and pelvis. They considered that these did not show the fracture that was seen in the images taken on 28 February 2014. The was

satisfied that the pubic ramus bone (which was found to be fractured on 28 February) had been seen in the x-ray of 18 February, and there was no fracture present. However, they considered that it was likely that the facture occurred during the first fall, but was 'undisplaced'. They explained that this is where the bone is not misaligned, and it explained why the bone outline looked normal on the initial x-rays.

86. Adviser 2 also reviewed the clinical assessments Mrs A had after her second fall. They considered that the assessments conducted on 21 February 2014 were inadequate, in that they did not take the history of deterioration and change in presentation into account. They said that matters were recorded without doctors taking their significance into account.

87. Adviser 3 reviewed the impact of the poor care and treatment that Mrs A received in Hospital 1. They noted that Mrs A had a severe and rapidly progressing dementia, and they considered that this caused her to develop delirium. However, they noted that the pain from her fracture may have contributed to the delirium and her general deterioration.

88. Adviser 3 also reviewed the evidence in relation to Mrs A's apparent urine infection. They noted that samples were taken on 18, 22 and 24 February 2014, and these all showed 'mixed growth' (meaning that no single organism was identified). They noted that the possible infection was initially treated with one form of antibiotic, and was later transferred to a different antibiotic. They considered this to have been reasonable. They also noted that Mrs A was examined during this time, and there was no suggestion that she had a distended or tender abdomen, suggestive of urinary retention.

89. Adviser 3 also reviewed Mrs A's care in relation to reports of a stiff neck. They considered that this was likely to be a result of her Lewy Body Dementia, and noted that other possible causes for this were ultimately eliminated. They did not consider that any other investigation or treatment of this symptom would have been appropriate in either Hospital 1 or 2. They, therefore, considered her care to be reasonable in this regard.

90. However, Adviser 3 also noted that, by 23 February 2014 Mrs A was clearly unwell, and he considered that, from that point, more attention should have been given to her physical health. They noted that on 24 February 2014 she was prescribed hysocine (an anti-spasmodic medication which aimed to

assist with her episodic abdominal pain). They noted that this medication reduces the ability of the bladder to contract, so it can cause urine retention, so they said that it may have contributed to the possible urinary retention she had when she was transferred to Hospital 2.

91. Adviser 3 said that Mrs A's dementia was so progressive that ultimately her care focused around other issues such as her swallowing and feeding, and management of infections. They considered that the main injustice to Mrs A was the additional pain, particularly in the days after her falls, which she would not have had to suffer if she had not had the falls and resultant fracture.

(c) Decision

92. Mrs A went into hospital mobile, and was on her feet a lot over her first 24 hours in hospital. She slept little and was even seen moving furniture. Within 48 hours of admission she was in obvious discomfort and was unable to bear her weight. She was seen by two doctors on 18 February, but neither of them noted her change in behaviour and mobility as being related to a physical problem. When the x-rays taken on 18 February 2014 did not identify a fracture, the doctors seem to have dismissed her lack of mobility and focused on an apparent urine infection.

93. While I appreciate that Mrs A presented staff with a range of issues, and it was difficult to identify the source of her pain, it is clear from the advice I have had that they did not do enough to consider what was causing her pain, or her changes in behaviour and continence.

94. I understand that Mrs A's dementia was progressing more rapidly than might have been expected, so her condition would have deteriorated even without her falls and fracture. However, I am concerned that when Mrs A presented with behaviour that indicated she was in pain, doctors did not do enough to try and relieve her pain, or assess what the cause of it was. When their initial investigations did not identify a the source, and when antibiotics for an apparent urine infection did not appear to be having any effect, they did not explore the matter further and did not take steps to ensure she was as safe as possible from further falls. On the basis of these failings, I uphold this complaint.

95. I am concerned that the failings identified above did not relate simply to the failings of one doctor. The systematic nature of the failure suggests wider

concern with the way the ward was being run and the way nursing staff worked with their medical colleagues. The recommendation above, that the Board conducts a significant incident review, can consider in greater detail what led staff to overlook significant changes in Mrs A's condition, even when these were highlighted by her family.

(d) The Board failed to keep accurate and comprehensive clinical and nursing records

Concerns raised by Mrs C

96. Mrs C kept her own notes of what happened while Mrs A was in hospital. From these, she identified a number of issues with the way that events were apparently recorded, based on how the Board responded to her complaints. In particular, she raised concerns in relation to recording of Mrs A's food and fluid intake, the use of hip protectors, her falls assessments, and recording of Mrs A's level of consciousness.

97. She highlighted concerns about the use of hip protectors. She said she never saw Mrs A wearing hip protectors, and that she had a conversation with one of the nurses about it. She said she offered to bring in hip protectors, but the nurse said they would provide them. She was critical that nursing notes referred to their use, of them being 'in situ', but she was clear that she never saw Mrs A wearing any.

98. Mrs C went on to say that she felt that the discrepancies between what she saw and what was recorded contributed to Mrs A's lack of care, because the notes gave staff a false sense of Mrs A's safety.

The Board's response

99. The Board's response to our enquiries did not provide any comments on inaccuracies in record-keeping. The response to Mrs C's complaint also did not identify any concerns about this.

Policy and Guidance

100. Both the General Medical Council's guide to Good Medical Practice and the Nursing and Midwifery Council's Code of professional standards specify the requirement for doctors and nurses to keep clear and accurate records of an event, at the time or as soon as possible after the event.

101. The expectations on hospitals in relation to food and fluid monitoring were contained in NHS Quality Improvement Scotland 'Fluid, Food and Nutritional Care in Hospital' (2003). This stated the hospital admission assessment should include screening for risk of under-nutrition, with subsequent assessments on an on-going basis. It specified that a care plan should be developed, implemented and evaluated. On this basis, a patient's intake of food and fluid should be monitored, and necessary action taken if intake is inadequate. This guidance also set out the Malnutrition Universal Screening Tool (MUST) as the instrument of choice for carrying out food, fluid and nutrition assessments. This process included an estimation of the patient's body mass index.

Medical advice

102. Adviser 1 reviewed Mrs A's medical records in relation to the issues raised by Mrs C. They highlighted that there was no specific document outlining a plan of care and that, without this, important issues were likely to be neglected. He was critical that record-keeping was mostly a retrospective account of care provided and events that took place. They noted that a multi-disciplinary care plan was left blank. Adviser 1 concluded that there was inadequate record-keeping in relation to Mrs A's care needs and planning, and this was unreasonable.

103. In relation to Mrs A's food and fluid intake, Adviser 1 could find no nutritional screening documentation in Mrs A's records, nor any evidence of a nutritional care plan. They noted that there was a blank food chart in the file, and no evidence of any monitoring of Mrs A's food and fluid intake or recording of her weight or body mass index. They concluded that practice and record-keeping in relation to Mrs A's food and fluid intake were unreasonable and fell well below national standards.

104. In relation to hip protectors, Adviser 1 noted the variations and inconsistencies in the medical records; that they were 'in situ' on 16 February 2014, but the next day records indicated that they were 'bringing in the precaution of hip protectors', suggesting that they were not already in use. The records also referred to hip protectors being discussed with the family on 20 February 2014. They mentioned that 'family were happy to purchase hipshields', though the family have said they were told the ward would order them.

105. Adviser 1 was critical that the Board, in their response to Mrs C's complaint, had asserted that hip protectors were in use from the day of admission, and that this was derived from a single, brief case note. They considered that record-keeping in relation to the use and evaluation of hip protectors for Mrs A was ineffective and fell below an acceptable standard.

106. In relation to Mrs A's falls assessments, Adviser 1 was also critical of the record-keeping. The details of this are provided above in relation to complaint (b). Adviser 1 assessed that the failure to date the Mores Falls Scale and the Falls Prevention Plan 'rendered them ineffectual as evidence of care planned and given'. They concluded that record-keeping in relation to falls prevention was below a reasonable standard.

107. Adviser 1 also found that there was no evidence of Mrs A's conscious level being monitored and charted.

108. Overall, Adviser 1 concluded that record-keeping was, in the main, retrospective. They was critical that nursing care was unplanned and the lack of record-keeping was an integral part of this.

(d) Decision

109. The failings in relation to record-keeping of Mrs A's care are wide-reaching. They did not only relate to an individual failure to record a specific event, though this certainly happened in that there is no record of an incident report relating to Mrs A's first fall. Adviser 1 was clear that the poor record-keeping included overall care planning, food and nutrition, falls prevention and use of hip protectors and consciousness.

110. I have also reviewed Mrs A's nursing records of her sleeping pattern and note that there were inconsistencies between the written notes of Mrs A's care and the records of her sleep.

111. I am concerned that staff were not aware of the need to maintain appropriate care plans, to monitor these and record this monitoring. This had a significant impact on the way care was planned, delivered, and then reassessed. It is my opinion that poor record-keeping of Mrs A's care went hand-in-hand with poor care planning and provision, and both were well below reasonable standards. I, therefore, uphold this complaint. Again, the

recommendation of a Significant Incident Review will enable the Board to identify how practice can be improved in this area.

(e) The Board failed to provide a reasonable response to Mrs C's complaint about Mrs A's care and treatment

Concerns raised by Mrs C

112. Mrs C reported to us that she could understand that mistakes were made in Mrs A's care and treatment, and that she was aware of the challenges that staff faced in caring for her. However, when she complained to the Board she had expected them to identify what had gone wrong, to apologise and to ensure the same mistakes did not happen again. She said that the response she got from the Board had been inaccurate; had not investigated what had happened in enough detail; or accepted fault when they should have. She said this made her feel upset and insulted, and made matters worse for her and her family. She considered the complaint response was poor and incorrect; that complaint handling staff were defensive; and that their questions were never fully answered. She also said their response made her more determined to pursue her complaint further and bring it to my office.

The Board's response

113. Mrs C wrote to the Board on 15 August 2014. The Board sent an acknowledgement of the complaint on 18 August and a full response on 10 September 2014. In their response they reviewed the care and treatment Mrs A had received from the Board each day of her admission to Hospital 1, based on what was in Mrs A's medical records. They then went on to respond to the specific questions which Mrs C had asked. Many of these responses indicated that decisions were made based on the clinical judgement of the doctors involved.

114. One of the questions Mrs C asked was why the doctors only sought a basic hip-x-ray on 18 February 2014, and did not include the pelvis and spine. The Board response was that Mrs A had been reviewed in the A&E department, and provided some details of the assessment. They noted that staff from Hospital 1 had requested x-rays of Mrs A's pelvis and right hip, and these were reviewed by Doctor 4 in A&E. The response also confirmed that these images had been reviewed by a consultant radiologist, who confirmed that no fractures were present.

115. After responding to Mrs C's specific questions, the Board went on to consider a number of other issues which she had raised, not specifically to do with Mrs A's care and treatment. This included communication with the family about Mrs A's care and treatment, among other issues. The response letter noted the large number of times that Mrs A's records indicated staff had spoken to Mrs C or her sister, and said they were 'sorry if you found the quality of the interactions to be lacking in some way'.

116. At the end of their response letter, the Board apologised that Mrs A had not been given the service that Mrs C 'might reasonably have expected', and that they had identified several learning points that they would take forward.

Policy and Guidance

117. The Board's Complaints Management Procedure (the Procedure) set out how complaints should be managed by staff. This required staff to acknowledge complaints within three working days, including a summary of the complaints made; empathy with the complainant's situation; outline any on-going investigations; and provide a copy of the factsheet on Feedback and Complaints.

118. The Procedure required an investigating officer to conduct an impartial investigation, in a supportive and non-adversarial way. They were also responsible for preparing a response to the complaint and for sharing this draft with relevant clinicians.

119. The final response letter should cover all the concerns raised in the complaint and should be clear, accurate, balanced and easy to understand. It should also include an explanation of planned action where the investigation has found that something can be done differently.

(e) Decision

120. The Board fulfilled their requirements in terms of the timescales of the Procedure, and provided a lengthy and detailed response to Mrs C's concerns. The investigation was carried out by a nurse manager from Hospital 1, and both the acknowledgement and response letters empathised with Mrs C's concerns. However, the content of the Board's response to Mrs C did not reflect this empathy in terms of the content of the letter as a whole.

121. The letter did not fully respond to the questions that Mrs C raised. Given the level of detail in Mrs C's complaint, which raised 28 specific questions, this would not have been easy. However, some of the answers that were given missed the point of the questions. For example, Mrs C asked why her mother was allowed to fall and hurt her head on 20 February 2014, when she had already fallen before. The Board responded 'the fall in which Mrs A sustained facial injuries was her second fall [as there had been a query over whether there were two or three falls] as she had a nurse with her at all times following this'. This did not provide Mrs C with any information as to why Mrs A had fallen for a second time, what action had been taken after the first fall to stop it happening again, and also did not identify any of the failings which were clear from our examination of Mrs A's records, in relation to falls prevention. It also did not address the provision of inaccurate information to Mrs C in the first place, due to inaccurate records in the medical notes.

122. I am also critical that the Board's response indicated that a falls assessment was carried out shortly after admission. If this was when the assessment was carried out, then the Board should have done more to identify why the expectations of the plan were not put in place (such as constant observations and the use of hip protectors) and why Mrs A fell despite this plan. None of this was explored in their response to Mrs C.

123. One of the concerns raised by Mrs C related to the inadequacy of the x-rays taken on 18 February 2014. Mrs C asked why the duty doctor only requested a basic hip-x-ray rather than including the pelvis and spine in the images. She was concerned that this led to Mrs A's hip fracture being missed. In fact, x-rays of the pelvis and right hip were requested, and a series of x-rays were taken that day, including views of the pelvis and both hips. Had this been clearly explained to Mrs C in the Board's response, she might have felt more satisfied that Mrs A's hip fracture was not evident at that time (as explained in complaint I above).

124. Overall, I found the Board's investigation of the complaint was inadequate, because they failed to identify failings which were clearly identifiable from the records. I am also critical that the Board's response to Mrs C's complaints was overly defensive or failed to provide enough detail for Mrs C to understand what had happened and why. It was not until the last paragraph that the Board apologised that the service provided to Mrs A 'did not meet with the standards that you might reasonably have expected'. They also said that learning actions

would follow. However, the letter did not make clear what should have happened; what failures there were; and what action points had been identified.

125. On the basis that the Board's response failed to provide a reasonable response to the complaints raised by Mrs C, I uphold this complaint.

126. I also recommend that the Board apologise in full for the failings identified in this report.

(e) Recommendation

127. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the failings identified in this report, both in relation to Mrs A's care and treatment and in relation to the response Mrs C received to her complaints.	20 January 2016

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

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mrs A	Mrs C's mother
Hospital 1	New Craigs Hospital
The Board	Highland NHS Board
Hospital 2	Raigmore Hospital
Adviser 1	psychiatric nursing adviser
Adviser 2	psychiatric adviser
Adviser 3	elderly medicine adviser
Doctor 1	locum consultant psychiatrist
Doctor 2	Duty consultant on 16 February 2014
Doctor 5	consultant psychiatrist; Mrs A's named consultant, who reviewed her care on 17, 21 and 24 February 2014
Doctor 3	junior doctor who saw Mrs A after her first fall on 18 February 2014
A&E	Accident and Emergency
Doctor 4	senior doctor in A&E at Hospital 2 on 18 February 2014
Doctor 6	GP trainee doctor who saw Mrs A on 22 February 2014

Doctor 7	consultant in medicine for the elderly, from Hospital 2
Doctor 8	junior doctor; duty doctor on 24 February 2014

Annex 2

Glossary of terms

computerised tomography (CT) scan	scan uses x-rays and a computer to create detailed images of the inside of the body
hip protectors	a padded band positioned around the hips, designed to absorb and deflect impact away from the hip bone during a fall; also known as hipshields
Morse Falls Scale	a measure of the risk of a patient suffering a fall
subcutaneous fluid	fluid injected under the skin

Annex 3

List of legislation and policies considered

Assessment and Prevention of Falls in Older People (2013), The National Institute for Health and Care Excellence

Code of Professional Standards (2015), Nursing and Midwifery Council

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

Good Medical Practice (2013), General Medical Council

National Guidelines for the Assessment of Pain in Older Adults (2007), Royal College of Physicians