SPSO decision report

Case: **201104503, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs A was an 87-year-old nursing home resident. She had Alzheimer's disease and a history of breast cancer and heart disease.

Mrs A was admitted to hospital after being found in the early hours of the morning on her bedroom floor after a fall. She was found to have fractured her hip. She had surgery in hospital the next day, and was discharged back to the nursing home two days later. Mrs A fell again in hospital on the morning of her discharge, but was medically assessed as uninjured.

Mrs A's daughter (Mrs C) believed that, despite providing one-to-one nursing to the best of their ability, staff at the nursing home struggled to manage her mother's care after her discharge because of her medical condition, impaired mobility and deteriorating cognitive function (the ability to think, concentrate, formulate ideas, reason and remember).

Mrs A fell again, from a chair, six days after being discharged from hospital. She had fractured her arm and was readmitted to hospital. Several days later, she was transferred to another hospital for palliative care (care to prevent or relieve suffering) and died shortly after.

Mrs C said that hospital staff failed to assess her mother's cognitive impairment and individualise her care and treatment, particularly in relation to falls prevention.

Mrs C held welfare power of attorney for her mother and believed that staff failed to communicate with her as they should have, about Mrs A's discharge. As a result of this, Mrs C said that Mrs A was improperly discharged and the board failed to ensure that adequate arrangements for later support were in place. Mrs C also said that they failed to implement an effective falls care plan for her mother, and failed to fully take into account her high falls risk on discharge. As a result, Mrs C believed that Mrs A's fall from the chair, which caused her severe suffering and proved fatal, was avoidable. Finally, Mrs C believed that the board misrepresented the findings of a visit by the Healthcare Inspectorate, a regulatory body. In responding to her complaint, the board said that it was found that ‘a high standard of care was being delivered to elderly patients with cognitive impairment’.

After taking independent advice from a medical adviser, who specialises in mental health issues, we upheld all of Mrs C's complaints. We found that the board's communication with Mrs A's family was unreasonable both in relation to the Adults with Incapacity (Scotland) Act 2000 and to discharge. We considered that a lack of meaningful consultation with Mrs C and the nursing home led to a significant personal injustice to Mrs A, as her discharge was ineffectively planned and coordinated and failed to ensure that her needs were met. We were also extremely concerned about the overall failures in communication, given the importance of meeting the needs of patients with dementia in every aspect of care, treatment and clinical management.

We found that the board failed to comply with their falls prevention policy in a number of important respects. This

was unacceptable. The risks of falling cannot be completely eliminated, but can be minimised by careful assessment and clinical management. Some measures were implemented for Mrs A, but additional measures should have been taken to further reduce the risks, given the potentially significant and severe consequences of a fall injury to an elderly person with dementia.

We found that there were a number of significant failures by the board in addressing Mrs A's mental health care needs. We were particularly concerned that Mrs A's cognitive function was not formally tested during her stay in hospital. Finally, we drew to the board's attention our finding that the Healthcare Inspectorate report had in fact highlighted the need for improvements in the areas of assessment and care-planning.

Recommendations

We recommended that the board:

- audit staff awareness of the board's policy on falls prevention and the knowledge and skills of staff relevant to its effective implementation, and take action to address any knowledge and skill gaps identified by the audit;
- review the fractured neck of femur care pathway to ensure it meets the needs of patients with dementia, in particular around assessment of cognitive functioning, pain assessment and communication under the Adults with Incapacity Act; and
- inform the Ombudsman of progress in implementing the action plan arising from the Healthcare Inspectorate report and how related clinical practice will be monitored and assessed.