Scottish Parliament Region: Glasgow

Case 201101255: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital – Care of the Elderly, clinical treatment

Overview

The complainant (Mr C) complained about the care his late father (Mr A) received at the Southern General Hospital (the Hospital) in February 2011. Mr C was concerned that the staff involved in Mr A's care had failed to consider and assess his cognitive function, or communicate with Mr C in relation to the plans for discharge, resulting in Mr A being inappropriately discharged. Mr A fell and was injured two days after being discharged home, and was re-admitted to the Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that Greater Glasgow and Clyde NHS Board (the Board):

(a) did not provide reasonable care and treatment to Mr A during his admission to the Hospital between 10 and 24 February 2011 (*upheld*);

(b) did not reasonably consider whether Mr A was fit for discharge on 24 February 2011 (*upheld*);

(c) did not dress Mr A in the outdoor clothes that had been provided for his journey home on 24 February 2011 (*upheld*); and

(d) did not provide a reasonable response to Mr C's complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide evidence to the Ombudsman of the implementation of a policy for the assessment of cognitive function of elderly patients, which should include documenting whether or not clinical staff find a patient has capacity to participate in decision making;	20 June 2012

(ii)	provide the Ombudsman with a copy of the new discharge policy to demonstrate it states that relatives and carers must be engaged with during the planning for discharge process;	20 June 2012
(iii)	ensure that their discharge policy and checklist contains a reminder that patients are dressed appropriately upon discharge;	9 May 2012
(iv)	provide a full apology to Mr C for all of the failings identified within this report; and	9 May 2012
(v)	review and clarify their policy in relation to the review of hip fracture patients by the DOME.	20 June 2012

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

Main Investigation Report

Introduction

1. Mr A was 85 years old. He lived at home alone, and had a number of health difficulties including heart and kidney problems, and low blood pressure. On 10 February 2011 Mr A fell at home and broke his hip. He was taken to the Southern General Hospital (the Hospital) and underwent a hip replacement operation on 12 February 2011. Shortly thereafter, Mr A was assessed as suitable for discharge. He was referred to the Discharge and Rehabilitation (DART) Team on 21 February 2011 for assessment and assistance in preparation for returning home.

2. Mr C, Mr A's son, raised concerns with staff in the DART team and nursing staff on the Orthopaedic Ward (the Ward) that Mr A was not ready for discharge given he had short-term memory loss and poor balance. He was concerned that Mr A was not ready to return home on his own so soon after his hip replacement operation. He felt the decision to discharge was inappropriate on this basis. Mr C also felt he was not consulted with appropriately in relation to the decision to discharge Mr A. The Hospital told Mr C that Mr A had advised the staff he was content with the arrangements for discharge.

3. Mr A was discharged home on 24 February 2011 having undergone a home visit with DART team staff on 22 February 2011 to assess potential hazards and identify suitable solutions to these.

4. Mr A was subsequently re-admitted to the Hospital on 26 February 2011 having fallen at home. He gradually deteriorated whilst in the Hospital, and remained there until his death on 19 March 2011.

5. Mr C complained to Greater Glasgow and Clyde NHS Board (the Board) on 10 March 2011 regarding the decision to discharge Mr A. He was concerned the staff responsible for caring for Mr A had not taken full regard of his short-term memory loss, and had not consulted with him as his father's next of kin in relation to decisions about his care and treatment. Mr C also stated that a number of other factors meant Mr A was not suitable for discharge on 24 February 2011, in particular that a blister on his foot and the recent hip replacement meant he was unsteady on his feet and could not weight bear fully on either foot. Mr C also complained that Mr A had not been appropriately dressed in outdoor clothing when discharged. Overall, Mr C felt the

deterioration of his father could be due at least in part to the decision to discharge him from Hospital on 24 February 2011. He stated that if Mr A's needs had been properly considered, subsequent events may have been preventable.

6. The Board responded to Mr C's complaints on 19 May 2011. Mr C remained dissatisfied with the response, as he felt the Board did not carry out a full and proper investigation of his complaints. Mr C complained to my office on 30 June 2011.

7. The complaints from Mr C which I have investigated are that the Board:

(a) did not provide reasonable care and treatment to Mr A during his admission to the Hospital between 10 and 24 February 2011;

(b) did not reasonably consider whether Mr A was fit for discharge on 24 February 2011;

(c) did not dress Mr A in the outdoor clothes that had been provided for his journey home on 24 February 2011; and

(d) did not provide a reasonable response to Mr C's complaint.

Investigation

8. In order to investigate Mr C's complaints, my complaints reviewer reviewed Mr A's medical records, and the complaints correspondence between the Independent Advice and Support Service (the IASS) on the behalf of Mr C and the Board. She made further enquiries of the Board in relation to records for Mr A for previous hospital admissions or out-patient appointments. She also obtained clinical and nursing advice from two of my advisers, a medical adviser (Adviser 1) and a nursing adviser (Adviser 2).

9. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr 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 during his admission to the Hospital between 10 and 24 February 2011

10. Mr C's main concern in relation to his father's care at the Hospital was that the staff who had decided upon and were preparing for Mr A's discharge had not reasonably taken into account Mr A's short-term memory loss. He was specifically concerned that they relied upon Mr A's ability to make reasonable decisions in relation to his own care and treatment, and the fact that on two

occasions the staff had given information to Mr A only, and relied on him to pass this on to family members. This was in relation to the requirement to bring outdoor clothing into the Ward so that the DART team[1] could assess Mr A on dressing, and that certain pieces of home-help equipment required to be collected from the Ward to be taken to Mr A's home. Mr A forgot to advise his family members of both these things, and Mr C felt this demonstrated he did not have the capacity to be involved in decision making. Mr C also stated he was told by staff on the Ward that as it was not a recuperative ward, his father would not be able to stay there long term.

11. Mr C also felt he was not reasonably consulted, as his father's noted next of kin, in relation to decisions about his care and treatment. Mr C was advised by his sister, Ms C, about the date of their father's discharge. Mr C was concerned the staff at the Ward had failed to notice his regular visits to see Mr A, and on that basis the decision to discharge was made following a discussion with Ms C and Mr A. Mr C also stated that Ms C herself had told the staff that they should more properly liaise with Mr C, given he lived nearer to Mr A and was more aware of his day-to-day living situation.

12. The Board responded in a letter to Mr C of 19 May 2011. They stated the DART team had had discussions with Mr C and Ms C in relation to Mr A's discharge. The Board also stated that Mr A had been unconcerned about returning home, and was in fact eager to do so. They explained that, when Mr C had been advised Mr A could not stay on the Ward long term, it was actually meant that Mr A could be allowed to return home once all necessary arrangements were in place. The Board apologised for any misunderstanding in this regard.

13. The Board stated that when the DART team visited Mr A to discuss the discharge, Ms C had been present, and on that basis they had not felt it necessary to contact the next of kin noted in Mr A's medical records. They also stated that during this discussion, neither Mr A nor Ms C had advised that Mr C should be consulted. They said Mr A had been content that matters were discussed with Ms C, and that they had respected his wishes.

[1] The actions of the DART team will be considered more fully within complaint b.

14. In complaining to my office, Mr C added that he felt it was inappropriate the Board allowed Mr A to decide who should be involved in discussions about his care.

Advice obtained

15. Adviser 1 stated that he could not conclude with certainty whether the care and treatment of Mr A in this regard had been reasonable. He said this was because at no stage during Mr A's time in the Hospital was any formal assessment of his cognitive function undertaken. He explained this was required in order to assess whether Mr A had the capacity to make decisions regarding his own welfare. In the absence of such assessment, Adviser 1 said there was circumstantial evidence to suggest that Mr A did not have any cognitive impairment, and other evidence to support the fact that he did. Factors against Mr A having cognitive impairment included: the fact he had signed a pre-operative consent form (although it was unclear how staff taking consent assessed capacity), that no member of medical staff had documented features suggesting cognitive impairment, and that Mr A had apparently lived in the community without formal support (but with input from his family) prior to his admission to the Hospital. Factors suggesting Mr A may have had cognitive impairment included that: Mr C had advised that Mr A had short-term memory loss, that Mr A had forgotten to pass along information to the family, that it had been noted upon Mr A's immediately subsequent admission that previous records relating to Mr A had stated he had a 'likely underlying degree of cognitive impairment', and that Mr A appeared to comply variably with the input of the DART team staff. Adviser 1 further noted that, given an early request by staff to Mr A resulted in no action (the requirement for one of Mr A's family members to bring in outdoor clothing) it was his view that this should have prompted staff to check directly with the family as to whether information had been transmitted to them by their father.

16. To assess this issue further, Adviser 1 considered Mr A's medical records relevant to out-patient appointments he had had within the preceding year. Adviser 1 noted that Mr A had attended an appointment at Renal Services at the Western General Hospital in November 2010; prior to this appointment, it had been noted that Mr A could possibly require formal assessment regarding his memory loss; however, no such assessment took place at the appointment. Adviser 1 concluded that, given all the available evidence, it was his opinion that Mr A did suffer some form of cognitive impairment. However, whether this was of sufficient severity to affect his capacity to participate in decision making

was impossible to ascertain due to the lack of formal assessment of cognitive function.

17. Adviser 1 explained there was no formal assessment by medical staff or nursing staff. He said the Abbreviated Mental Test box of the medical clerking document had not been completed, that the nursing patient profile admission document did not appear to seek any information regarding cognition, and that the nursing discharge form under mental state only noted 'alert and oriented', which did not constitute sufficient information to make any conclusion regarding cognitive function. He noted that the Board advised this office there is no policy for routine screening for cognitive impairment in the Ward, and that nursing staff have no training in this regard. He stated that despite this the staff had nonetheless acted in good faith, and appropriately for a patient who they believed had capacity.

18. Adviser 1 concluded it was regrettable that the Ward had no screening processes for cognitive function, particularly given they deal with many older patients. He acknowledged that, at the present time, it was not unusual for Boards to lack these processes, or to formally consider a patient's capacity to participate in decision making, but that nevertheless, this was below a standard that should now be expected. He explained the Government had recently introduced a new framework in relation to 'Older People in Acute Care[2]' which was relevant to this aspect of care for the elderly.

19. Adviser 1 went on to consider the Board's position that Mr A had expressed a wish to go home. He explained that even patients with cognitive impairment of a significant level may still say they wish to go home, in part because a lack of insight and judgment are components of cognitive impairment. On the other hand, Adviser 1 explained that even if a patient lacked capacity, one would still attempt where possible to follow their wishes and/or the 'least restrictive option'; that is, if a patient without capacity wished to return home, care staff should still actively seek to effect this outcome, unless it was felt too risky. Adviser 1 said this meant it was appropriate for staff to aim for home in Mr A's case, providing appropriate risk assessment was undertaken and suitable care arranged (which will be considered more fully within complaint b).

[2] Healthcare Improvement Scotland – Older People in Acute Care – Self Assessment, October 2011.

20. Adviser 1 considered the issue of communication with the family. He explained that if Mr A had in fact had capacity, there was no need to discuss decisions with next of kin, but it would be good practice to inform them of any decisions. If Mr A did not have capacity, it would be necessary to discuss decisions with the closest kin or nominated legal representative. Because staff had accepted Mr A had capacity, they had accepted his view that he was content with Ms C being primarily involved in the discussion about discharge. Adviser 1 noted communications with Mr C took place once concerns had been raised. Adviser 1 said matters were complicated by the doubts about Mr A's capacity, the fact Mr C had apparently asked specifically to be communicated with, and that Ms C had emphasised the need to involve Mr C. Adviser 1 said on balance it would have been sensible and preferable for Mr C to be directly involved in communication, but that overall the level of communication that actually occurred could not be said to be below a reasonable standard.

(a) Conclusion

21. Mr C's complaint on this aspect of Mr A's care has raised some very difficult issues. The fact that Adviser 1 has been unable to state whether the care and treatment given was reasonable due to a lack of formal assessment of Mr A's cognitive capacity in itself gives me cause for concern about how reasonable the care and treatment given in fact was. Whilst acknowledging the advice given to me that, in the event that Mr A did have appropriate capacity then staff were acting reasonably and in good faith, I am critical of the Board that there is no way to evaluate this meaningfully.

22. I find that there were a number of factors in Mr A's case that could have alerted staff to the fact that Mr A should have undergone some form of formal assessment of his cognitive function, in particular Mr C raising with them his concerns about his father's short-term memory loss, the fact Mr A had forgotten on two occasions to pass on information to his family, and that Mr A had previously been identified during an out-patient appointment as requiring such an assessment.

23. I also take into account Adviser 1’s conclusion that Mr A likely did have some form of cognitive impairment, although the impact of this upon his capacity is unknown. I note that there is new Government policy in relation to this aspect of care of elderly people, and I would expect the Board to give

detailed consideration to this. On that basis I uphold this complaint and have one recommendation to make.

(a) Recommendation

24. I recommend that the Board:	*Completion date*
(i) provide evidence to the Ombudsman of the implementation of a policy for the assessment of cognitive function of elderly patients, which should include documenting whether or not clinical staff find a patient has capacity to participate in decision making.	20 June 2012

(b) The Board did not reasonably consider whether Mr A was fit for discharge on 24 February 2011

25. Mr C was also concerned that the Board had not reasonably considered Mr A's physical fitness for discharge. He stated that, following Mr A's hip replacement operation on 12 February 2011, the staff attempted to teach him to use a Zimmer frame the following day. He said that Mr A had been weak and frail with poor balance even before the fall, and that he had advised the staff of this. Mr C also said that Mr A's short-term memory loss meant he could not remember instructions about how to use the Zimmer frame. He added that Mr A had a severe blister on one of his feet which had impacted upon his ability to weight bear on both feet. He said the bandage applied to this blister had also affected Mr A's ability to operate the Zimmer frame safely.

26. Mr C stated he had spoken with the DART team and raised concerns about Mr A's house being inadequately prepared for his return. He stated Mr A's chair was too low, as was the toilet seat, and there were probably other hazards he was not aware of. A home visit was carried out on 22 February 2011 in response to these concerns. Mr C said he was also advised on Mr A's return home that Mr A had developed a urinary tract infection. Mr C believed this had to have been diagnosed prior to Mr A's discharge, and was another reason why Mr A should not have been discharged from the Hospital, as it indicated he was not fully well. Mr C also stated Mr A had never been assessed as to how he would put on outdoor clothes.

27. Mr C was concerned that the failure to properly considered these factors may have contributed to Mr A's subsequent fall and re-admission to the Hospital two days later. Mr A fell and injured his head during the night of

25/26 February 2011. He was re-admitted to the Hospital having suffered a head injury and the surgical wound on his hip having re-opened. Thereafter, Mr A did not appear to recognise members of his family and had difficulty communicating. He was bruised as a result of the fall, and a computed tomography (CT) scan revealed bleeding on the brain. He died in the Hospital on 19 March 2011.

28. The Board explained that, if a patient is assessed as being fit for discharge prior to a bed becoming available in the elderly care rehabilitation ward, then that patient can be discharged directly home. They stated the decision to discharge was one that was agreed by all members of the multi-disciplinary team (the MDT), that the team had felt Mr A was progressing well, and thereafter referred him to the DART team for further assessment and preparation. The DART team consists of nurses, occupational therapists and physiotherapists. A pre-discharge assessment of Mr A had been carried out between 20 and 23 February 2011 by the DART team. The assessment had found Mr A to be independent with his Zimmer frame and independent with chair, bed and toilet transfers. They stated that Mr A had been happy with the DART team intervention, and had engaged with the DART team to regain his independence.

29. The Board also stated that the plan was for Mr A to receive ongoing support; that a homecare service had been arranged for four times per day visits to assist Mr A with activities such as washing, dressing and meal preparation, that district nurses would change the bandage on his foot and monitor this, that a physiotherapist would progress his mobility from the Zimmer frame to elbow crutches, and that an occupational therapist would continue to assess his daily activities.

30. The Board said the physiotherapist had noted no evidence of confusion whilst assessing Mr A, and that he had been fully competent with the use of the Zimmer frame. The Board explained that the DART team had provided a free standing toilet frame to assist Mr A in using the toilet, and that he had been assessed with this piece of equipment on 21 February 2011 in the Occupational Therapy (Activities of Daily Living) Suite. The Board also stated that on this date Mr A had completed a kitchen assessment which demonstrated he was independently mobile, sequenced tasks appropriately and demonstrated good safety awareness.

31. The Board stated that Mr A had been visited at home by a physiotherapist on 25 February 2011 and was found to be safe but slow with the Zimmer frame. He was provided with a prescribed exercise programme. In complaining to my office, Mr C stated the Board's response in this regard had failed to properly conclude that Mr A could only use the Zimmer frame when supervised.

32. In relation to the urinary tract infection, the Board stated that they had checked Mr A's microbiology results and found that Mr A did not have a known urinary tract infection when discharged, as the last urine sample sent to microbiology was sent on 14 February 2011 and was negative.

33. The Board provided documentation relating to the home visit undertaken on 22 February 2011 to my office. It showed that Mr A's home environment had been assessed, and it was proposed Mr C would purchase a new, higher chair for Mr A, that the DART team would order bedraisers for the bedroom to assist Mr A with bed transfers, and as noted previously that a toilet frame would be provided. In complaining to my office, Mr C stated (as mentioned within complaint a) that the equipment mentioned by the Board had been left at Mr A's bedside for collection by family members, but that the family had not been advised of this directly and the DART team had relied upon Mr A to pass this information along.

34. The Board apologised that Mr A had not been assessed as to how he would put on outdoor clothes. They explained he had been assessed in relation to donning and doffing pyjama bottoms and slippers, and that on 18 February 2011 Mr A had declined occupational therapy intervention. They stated the last notes in this regard taken on 21 February 2011 stated that further dressing practice was required, but that it did not appear thereafter that a full dressing assessment had been completed. The Board stated they had discussed this with the staff concerned.

Advice obtained

35. Adviser 2 stated that the preparation for discharge was well documented within Mr A's medical records, and that the DART team had provided a good assessment and onward plan which ensured a package of care for Mr A was in place, including physiotherapy services, occupational therapy and nursing input. She stated that the DART team had focussed on the wishes of Mr A, noting that returning home was his preferred choice.

36. Adviser 1 stated that the DART team process in Mr A's case appeared to have been reasonably co-ordinated and integrated into the mainstream ward care. He noted, however, that there was only limited evidence of any medical input into the discharge decision-making process. He stated that the information provided by the Board suggested that the DART team had structured links with a named geriatrician for advice and reviews, and that they would meet with the geriatrician fortnightly. Adviser 1 stated it was unclear whether advice was ever requested regarding Mr A.

37. Adviser 1 noted that the home visit was good practice, as was the presence of Mr C at this visit. He stated that the DART team had documented Mr C's concerns and had appeared to have discussed these with him at the time. Adviser 1 said it was unsatisfactory that Mr A was discharged without having been fully assessed in relation to his ability to dress. He noted the Board had apologised for this. Adviser 1 said it appeared that the presence of Mr A's urinary tract infection had been noted upon his re-admission. He said this did not imply the infection should have been detected pre-discharge.

38. Adviser 1 said that the fact the early re-admission occurred did not necessarily imply that the initial discharge was flawed or that care in another unit would have prevented this outcome. However, he commented that the DART team screening documentation made no reference to cognitive function, and that it was not clear from the Board's response whether the specific DART team members had any training in cognitive function assessment. He concluded that the failure to formally and objectively assess whether Mr A had cognitive impairment (as considered within complaint a) resulted in an incomplete assessment and therefore was below a standard which could reasonably be expected.

(b) Conclusion

39. I have carefully considered Mr C's position and concerns, the information provided by the Board and the advice given to me in relation to this complaint. I find that the DART team acted reasonably overall, generally assessed Mr A adequately, and put in place an appropriate ongoing package of care for him. However, it must follow that, as with complaint a, given no formal assessment of Mr A's capacity took place at any time, I cannot conclude that the Board reasonably considered whether Mr A was fit for discharge. This is because the Board's failure to undertake such assessment meant that all actions and

preparations that followed cannot be said to have fully considered the capacity of Mr A.

40. It is impossible to state whether or not such an assessment would have resulted in a different course of care, and it is also unclear whether increased medical input would have changed the course of care given no formal assessment of cognitive function was carried out by medical staff in any event. I give regard to the anxiety and concern caused to Mr C as to whether his father had been properly assessed for discharge home, particularly given what subsequently occurred. It is important that patients, relatives and carers feel that they are being listened to and their views are being taken into account during the process of planning for discharge. I uphold this complaint. I have one recommendation, and I would also expect the recommendation made in relation to complaint a to incorporate suitable arrangements for training and provisions for formal assessment of cognitive function documentation for DART team staff.

(b) Recommendation

41. I recommend that the Board:	*Completion date*
(i) provide the Ombudsman with a copy of the new discharge policy to demonstrate it states that relatives and carers must be engaged with during the planning for discharge process.	20 June 2012

(c) The Board did not dress Mr A in the outdoor clothes that had been provided for his journey home on 24 February 2011

42. Mr A was discharged home by ambulance on 24 February 2011. Mr C stated Mr A was dressed in outdoor trousers, one slipper, a polo shirt and a dressing gown and was extremely cold. He stated that the bandage on his foot had become loose and wet due to walking outside. Mr C was waiting for Mr A at his house, and stated the paramedics transporting Mr A gave Mr C Mr A's suitcase, which contained his outdoor jacket, a hat, jumper and outdoor shoes. Mr C questioned why Mr A had not been dressed appropriately in these items for the winter weather on his journey home.

43. The Board stated that the nursing staff had been spoken to in relation to this incident. They had explained that the ambulance had arrived earlier than expected and that they had been trying to organise Mr A quickly. They explained the nursing staff had put Mr A's dressing gown on him to try and keep

him warm. The Board apologised that the nursing staff had failed to notice Mr A's outdoor jacket in his belongings. The Board said their discussion with the staff concerned would ensure this type of incident did not occur again, and the appropriate dressing of a patient for return home would now be documented as part of the discharge checklist for staff.

Advice obtained

44. Adviser 2 noted that the reason given for the manner in which Mr A was dressed on his return home was clearly not acceptable. She noted the Board had apologised for this and taken action. Adviser 1 also noted this had been an unsatisfactory aspect of Mr A's care.

(c) Conclusion

45. I find that this was an unfortunate incident which could well have been avoided if staff had taken the time to check through Mr A's belongings properly and dress him suitably for the winter weather. It was not acceptable that an elderly and frail man was discharged from the Hospital dressed in this manner. I can understand why this occurrence raised additional concerns with Mr C about his father's care whilst in the Hospital. I uphold this complaint and have one recommendation to make, whilst noting this incident has been appropriately acknowledged and apologised for by the Board, and that action has been taken as a result of Mr C drawing this matter to the Board's attention.

(c) Recommendation

46. I recommend that the Board:	*Completion date*
(i) ensure that their discharge policy and checklist contains a reminder that patients are dressed appropriately upon discharge.	9 May 2012

(d) The Board did not provide a reasonable response to Mr C's complaint

47. Mr C was concerned that the Board's response to his letter of complaint of 10 March 2011 did not reasonably address all of the issues he had raised. In particular, he stated that the Board had failed to acknowledge his father's short-term memory loss or poor balance, both of which he had referred to several times within his letter of complaint. He was also concerned that the Board did not gather information relative to the plan for discharge during a discussion with Ms C and himself as they had stated within their response of 19 May 2011; Mr C felt the Board may have been confused between family members.

Advice obtained

48. Adviser 1 stated the response from the Board was comprehensive and generally accurate. However, he noted the phrase 'extensive and thorough assessment' as used to describe the process by which Mr A was prepared for discharge failed to acknowledge that there was no formal assessment of cognitive function.

49. Adviser 1 also commented that the Board's response demonstrated a lack of clarity regarding which elderly orthopaedic patients are seen by the Department of Medicine for the Elderly (the DOME). He said it was stated that patients with femur injuries are 'usually' referred to the DOME, unless they meet the criteria for DART team referral. In subsequent information provided to this office, the Board stated 'there is not written criteria for referral to the DOME however medical staff would routinely review … all hip fracture patients'. Adviser 1 noted if this was the case then Mr A did not appear to have been managed as per the Board's protocol, as no DOME review occurred until re-admission. Adviser 1 said the Board had not explained whether or not they found Mr A should have been reviewed by the DOME.

(d) Conclusion

50. In relation to this complaint, I find that in some respects the Board's response to Mr C's complaints is comprehensive and detailed. Although it did not specifically respond to or comment on Mr C's position that Mr A had short-term memory loss and poor balance, the Board's position at that time was that Mr A had shown 'no evidence of confusion' and had demonstrated to DART team staff that he was able to use a Zimmer frame. It appears the Board have attempted to address these points without explicit reference to the terms Mr C used in his letter. I note the Board also provided answers to each of the specific questions posed by Mr C at the conclusion of his letter of complaint. Of course, my conclusions in relation to the first two complaints in this report have found that the Board's response in this regard were inadequate overall in any event given the lack of formal assessment of cognitive function.

51. In relation to the issue about discussions with Mr C and Ms C about the discharge of Mr A, it seems there could be two interpretations of this; one, that staff held a discussion at which both Mr C and Ms C were present, (which Mr C refutes) or that discussions were held with both Mr C and Ms C regarding their father's discharge, which the documentary evidence available indicates did

occur. I find the Board could have been clearer in this regard to prevent the misunderstanding which has subsequently arisen.

52. The advice given to me has also highlighted a lack of clarity in the Board's response in relation to their policy of referring patients to the DOME which, although not specifically referred to by Mr C in his complaints, I find is of sufficient significance to draw to the Board's attention nonetheless. On balance, I uphold this complaint and have two recommendations to make.

(d) Recommendation

53. I recommend that the Board:	*Completion date*
(i) review and clarify their policy in relation to the review of hip fracture patients by the DOME.	20 June 2012

General Recommendation

54. I recommend that the Board:	*Completion date*
(i) provide a full apology to Mr C for all of the failings identified within this report; and	9 May 2012

55. The Board have accepted all of 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 aggrieved, the complainant's late father
The Hospital	Southern General Hospital
The DART	The Discharge and Rehabilitation Team
Mr C	The complainant
The Ward	Ward 1 within the Orthopaedic Department of the Southern General Hospital
The Board	Greater Glasgow and Clyde NHS Board
The IASS	The Independent Advise and Support Service that assisted Mr C in making his complaints
Adviser 1	The Ombudsman's medical adviser
Adviser 2	The Ombudsman's nursing adviser
Ms C	The complainant's sister
The MDT	The multi-disciplinary team at the Hospital responsible for making decisions about Mr A's care
The DOME	The Department of Medicine for the Elderly

Annex 2

Glossary of terms

Abbreviated Mental Test	A quick to use screening test for assessing capacity

Annex 3

List of legislation and policies considered

Healthcare Improvement Scotland – Older People in Acute Care – Self Assessment, October 2011