SPSO decision report

Case: **201103772, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, action taken by body to remedy, no recommendations

Summary

Ms C complained about her late mother's (Mrs A) care and treatment in hospital. Mrs A fell while in hospital as an in-patient.

Ms C said that, due to her mother's risk of falling, it had previously been agreed that she should always be accompanied to the bathroom. However, in September 2011, Mrs A fell when she went there on her own. Mrs A was found and returned to bed by staff but, Ms C said, she was not properly examined and a doctor was not asked to examine her. Ms C considered this inappropriate because her mother had a history of falls, had recently broken her hip and had osteoporosis. Ms C said that her mother was eventually sent to another hospital for x-rays after she saw a doctor the next day. However, she alleged that the nurse accompanying Mrs A there did not have proper instructions and Mrs A's neck was not x-rayed.

Ms C said her mother complained of neck pain on her return, and was referred back to the other hospital the next day for a neck x-ray. It was established that she had a neck fracture. Mrs A later died and Mrs C believed that this was as an indirect result of what she considered to be the lack of care in September 2011.

We obtained independent advice from our nursing adviser and a medical adviser, who considered Mrs A's medical records. Our nursing adviser said that while Mrs A was known to be at risk of falling and that it had been agreed that she was to be accompanied to the bathroom, she was not considered to need 24 hour observation. The nursing adviser said there was also a balance to be achieved between promoting independence and mobility, and the need to assist. In her opinion, the adviser said that the hospital took all reasonable steps to prevent falls and promote mobility but that Mrs A had gone alone to the bathroom without being seen.

On being discovered after her fall, we found that Mrs A was given first aid and observations were commenced. The nursing staff consulted on-call medical staff who said they should continue with observations every two hours, with a medical review taking place the next day. If anything changed, nursing staff were to contact the on-call medical staff again. The medical adviser said that Mrs A was sent to the other hospital with a referral letter (which they said was of good quality) but essentially she was being sent for review and it was the responsibility of the receiving doctor to decide what treatment to give. The receiving doctor did that and discussed the matter with his superior. A neck x-ray was not carried out. The nursing adviser also confirmed that the member of staff accompanying her was acting as a chaperone.

Taking all of the above into account, we did not uphold Ms C's complaints about her late mother's care and treatment. We did, however, uphold her complaint about their complaints handling. Ms C had said that she found the board's replies confusing and contradictory. We reviewed the correspondence during our investigation and found that the information passed to Ms C was indeed contradictory. As, however, the board had already acknowledged this and apologised, we did not make any recommendation.