SPSO decision report

Case: **201407185, Western Isles NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment of his late wife (Mrs C) during several admissions to Western Isles Hospital, following a fall. Mr C said they were initially told there were no breaks or fractures, but he found out over a week later that in fact Mrs C had several rib fractures. He then found out several weeks after this that Mrs C also had a fractured vertebra. Mr C complained about the delay in diagnosing the fractures, and raised concerns about the overall medical and nursing care. He also said staff told him he would be refunded for his expenses when he accompanied Mrs C to a hospital on the mainland, but the board later refused to reimburse him.

The board explained that Mrs C was very ill, with a severe chest infection and a number of medical conditions. They said the rib fractures appeared to be old, and would not have changed her treatment. They also said Mr C was not eligible to be reimbursed for his expenses under their travel policy (and they had updated their information leaflet to make this clearer). The board agreed that some aspects of Mrs C's care could have been better, in particular management of her diabetes, and they took actions to improve this.

After taking independent medical and nursing advice, we upheld two of Mr C's complaints. We were not critical that staff did not identify Mrs C's fractures on the original x-rays, but we were concerned that there was a delay in the reporting of scans, which meant that staff were unaware of Mrs C's fractures for some time. We also found that staff failed to investigate a new symptom of pain when Mrs C returned to hospital a few days after her fall. Finally, we found there was evidence that nursing staff thought Mr C was eligible for reimbursement under the travel policy (so it was likely they gave him inaccurate information about this).

Recommendations

We recommended that the board:

- feedback our findings to the staff involved for reflection and learning;
- review their process for reporting on x-rays to ensure reports are completed within a reasonable timeframe;
- ensure relevant staff discuss the radiology adviser's comments on the scan at a discrepancy meeting;
- apologise to Mr C for the failings our investigation identified; and
- remind staff that the travel policy does not apply in relation to patients transferred by ambulance, or patients transferred between treatment centres.