

## SPSO decision report

**Case:** 201708376, Highland NHS Board  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

Mrs C complained about the care and treatment her late mother (Mrs A) had received in Raigmore Hospital before her death. Mrs A had been referred to the hospital by her GP. The referral letter said she had fallen at home and referred to acute kidney injury. Mrs A fell on two occasions after being admitted to hospital. It was then identified nearly three weeks later that she had fractured her hip. Mrs A later died in the hospital.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly) and a nursing adviser. We found that the care and treatment provided to Mrs A in relation to her kidney function was reasonable and appropriate. In addition, she had not displayed sufficient pain or deformity that meant a hip fracture should have been considered. However, the nursing records indicated that Mrs A was at risk of falling, but there was inadequate information about what action would be taken to prevent any falls. We found that it was reasonable for staff to try to reduce Mrs A's agitation after her first fall by allowing her to walk with a member of staff, but it would have been more appropriate to have had two members of staff with her. Staff should also have told the family about the first fall when they contacted them about the second fall.

In view of these failings, we upheld Mrs C's complaint, although we noted that the board had already apologised to Mrs C and had taken a number of actions to try to prevent similar failings in the future.

### Recommendations

What we said should change to put things right in future:

- Nursing staff should ensure that the relevant nursing documentation is completed appropriately.