SPSO decision report

Case: **202104942, Grampian NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C, an advocate, submitted a complaint on behalf of the family of A. A was a resident of a care home and attended hospital with low potassium levels. A later sustained a leg fracture around the time of the first discharge and was re-admitted to hospital. A later died. C complained that the nursing and medical care provided by the board was unreasonable.

We took independent advice from a nurse, consultant orthopaedic surgeon and consultant geriatrician. We found that there were failings in the nursing and medical care provided and that the board failed to carry out a reasonable investigation into the concerns raised. We also found that A did not receive appropriate care and treatment after they sustained a leg fracture. Specifically, there was a lack of recorded consultant input, delays in having a second cast fitted and delays with A being discharged afterward.

In addition, the concerns raised regarding how the leg fracture occurred weren't appropriately investigated across multiple agencies and it took a number of contacts by both C and the SPSO before a full response was provided. Therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the failings identified in relation to the investigation and treatment of A's fracture and their discharge from hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Consultant ward rounds, particularly at the weekend, should review all patients and should be documented.
- Frail elderly patients with fractures should receive appropriate orthogeriatric support.
- Patients should be discharged as soon as clinically appropriate following treatment.
- When harm comes to a patient and there are multiple organisations involved as to where the injury may have occurred, a multi-agency review is carried out in a timeous manner.

In relation to complaints handling, we recommended:

- Evidence that the learning from this complaint has been shared at an Acute Sector Clinical Governance Group.
- Evidence that the learning from this complaint has been shared via the Acute Sector Clinical Risk Management Group.
- Evidence that the learning from this complaint has been shared via the Board's Clinical Governance

structures.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.