

SPSO decision report



Case: 202304267, Lanarkshire NHS Board
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the medical and nursing care they received for a spinal condition. C said the care led to avoidable complications and delayed their transfer to a specialist spinal unit.

We took independent advice from a consultant in orthopaedics (specialists in the treatment of diseases and injuries of the musculoskeletal system) and a registered nurse. We found a number of failings in the nursing care C received. This included poor record keeping and a failure to manage C's skin care appropriately. This led to avoidable pressure injuries which were a significant factor in delaying C's transfer. In terms of medical care, we found that the ward C was placed on lacked the necessary equipment to manage a patient in their condition. We found the medical and nursing care C received fell below a reasonable standard and upheld these parts of C's complaint.

C also complained that the board failed to provide them with a reasonable standard of physiotherapy. We found that C's physiotherapy care was of a reasonable standard and was well documented, showing regular review up to the point physiotherapy was stopped on medical advice. Therefore, we did not uphold this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide them with a reasonable standard of medical and nursing care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

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

- Wound charts should be in place for pressure wounds and there should be subsequent weekly assessments. Care rounding should be delivered to the frequency required to prevent pressure damage. Patients should be appropriately moved position to avoid worsening pressure damage.
- Nursing staff correctly follow CPR for feet guidelines and develop person centred treatment plan for patient foot care.
- Patients should be transferred to a hospital and ward which can provide the care they need.
- That a duty of candour review is considered in light of the SPSO's findings.
- When a relevant adverse event occurs, the board should complete a SAER.

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.