SPSO decision report

Case: **201103592, Grampian NHS Board**
Sector: health
Subject: communication and complaints handling
Outcome: upheld, recommendations

Summary

Ms C was injured when there was an accident involving the stair lift on which she was being transported by a member of the Scottish Ambulance Service (the Service) to a hospital appointment. She complained that, following the accident, she reported the matter to the receptionist at the clinic and was told that someone (apparently the lead nurse of the clinic) would come to see her. This did not happen before Ms C was collected again by the Service for transport home.

Ms C also complained that despite being in pain from her injuries no hospital staff came to check her over. She also said that when the board responded to her complaints the letters contained inaccurate information, including referring to her injuries being caused when she was 'putting her aunt onto the stair lift' and that she had been 'walking with the consultant' within the clinic. Ms C was in fact in a wheelchair the whole time she was in the clinic on this day.

We upheld all of Ms C's complaints and made relevant recommendations. The board acknowledged that the incident had occurred (while Ms C was in the care of the Service) and that Ms C had made hospital staff aware that it had happened. Although a member of staff checked with the Service that they knew about the matter, no action was taken to report it within the hospital's own policy on accidents. The board had not referred in their response to the failure of the lead nurse to come to speak to Ms C while she was in the clinic.

On the matter of Ms C not being checked over, the board said that the consultant that Ms C was there to see recalled Ms C mentioning that she had had an accident but not that she had been injured and/or was in pain. They also said that none of the other staff had any recollection either of Ms C saying she was in pain or that she seemed to be in pain. Although there was no conclusive evidence to support either version of events, we found that although aware that there had been an accident, there was little evidence to suggest that

staff had taken steps to find out how Ms C was after it happened. On balance, therefore, we took the view that little or no effort had been made by staff to establish the extent of Ms C's injuries and/or pain.

On the issue of their complaint response, the board acknowledged that there were errors in two letters. In particular, the chief executive said that the comment about Ms C walking within the clinic was based on the recollections of staff from a previous visit to the clinic by Ms C. The chief executive accepted that on the day in question Ms C was in a wheelchair the whole time she was in the clinic.

Recommendations

We recommended that the board:

- apologise to Ms C for the failures identified; and
- review the policy and procedures for reporting accidents and ensure that all staff are aware of the policy and their responsibilities within it.