SPSO decision report

SPSO Scottish Public Services Ombudsman

Case:	**201202973, Greater Glasgow and Clyde NHS Board**
Sector:	health
Subject:	clinical treatment / diagnosis
Outcome:	some upheld, recommendations

Summary

Mrs C complained about the care and treatment her late mother (Mrs A) received at the Western Infirmary, Gartnavel General Hospital and Victoria Infirmary. Mrs A was initially admitted to the Western when she fell and fractured her hip. She had a hip replacement operation and was transferred to Gartnavel. Mrs C said that as Mrs A had developed pressure ulcers on her foot she was discharged home too soon, only to be admitted to the Victoria two days later, having fallen again. Mrs C had further concerns about the care of the pressure ulcers and a lack of physiotherapy, and said that her mother was again discharged too soon because she then had several more falls and had to go back to hospital.

We took independent advice on this case from three of our advisers (specialising in nursing, physiotherapy and acute medicine for older people). Mrs A had been assessed as being at high risk of developing pressure ulcers, but we found no evidence that nursing staff at Gartnavel and Victoria hospitals monitored her for this. Although a special pressure relieving boot was provided after the pressure ulcer was identified, staff did not start a wound chart to monitor and assess the ulcer as they should have done. We concluded that the nursing care in both these hospitals fell below a reasonable standard, and was not in accordance with guidance issued by NHS Quality Improvement Scotland. The board also acknowledged a delay of around 12 days in Mrs A starting physiotherapy in the Victoria after she had a short period of illness. We said that this was unreasonable, and prolonged her stay there.

In relation to Mrs A's discharge from Gartnavel, our adviser said that in itself a fall shortly after discharge would not mean the discharge was inappropriate. Although we were highly critical of the board for having lost some of Mrs A's medical records, we decided that evidence from the physiotherapy, occupational therapy and nursing records showed that Mrs A's mobility was reasonably assessed, and no significant changes were noted before she was discharged. In addition, there was evidence showing that the second discharge from the Victoria was appropriate and referrals had been made for Mrs A to continue to have her needs assessed at home.

Recommendations

We recommended that the board:

- audit a sample of patient records at Gartnavel General Hospital and the Victoria Infirmary to ensure skin risk assessments are being conducted, and appropriate care plans are in place in accordance with NHS Quality Improvement Scotland guidance;
- ensure patients in the Victoria Infirmary are promptly reviewed by physiotherapy after a period of sickness;
- apologise to Mrs C for losing Mrs A's medical records and for failing to identify that they were missing when responding to the complaint;
- review their practice on the storage of patients' medical records to prevent a recurrence of failing to store medical records securely; and
- ensure patients are referred in good time to the appropriate community rehabilitation team in preparation for discharge from Gartnavel General Hospital.