SPSO decision report

Case: **201301800, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained to us on behalf of her late mother (Mrs A) about the care and treatment she received in the Royal Victoria Hospital during the last three months of her life. Mrs A had fallen while in hospital. Over subsequent weeks her mobility deteriorated and she complained about pain in her hip. Mrs A was referred for a psychiatric review and then a pain assessment that highlighted concerns about her condition. She was referred for an x-ray, which identified a fractured hip. Mrs C complained that this should have been identified earlier, and that staff did not do enough to adequately manage Mrs A's pain. She said that if the hip pain had been appropriately investigated, Mrs A would have had better pain control in the final weeks of her life.

We sought independent advice from a nursing adviser and an adviser in elderly medicine. The nursing adviser highlighted significant concerns about the assessment and monitoring of Mrs A's pain. They were also critical that nurses made negative remarks about Mrs A's behaviour, without noting that the behaviour was a result of her pain.

The adviser in elderly medicine found that doctors had appropriately assessed Mrs A after her falls. They noted that Mrs A had complex care needs, and her pain had a number of sources. However, they were critical that when Mrs A started to complain of pain in her hip about a month after her last fall, this was not further investigated. They said that if the fracture had been identified then, Mrs A could have received better pain management in the weeks before she died.

We were critical that the nursing staff did not do enough to appropriately assess Mrs A's pain as her condition deteriorated. This made it more difficult for doctors to assess her. However, medical staff also failed to identify significant signs of a potential hip fracture for several weeks, and this left Mrs A with poor pain management for longer than necessary.

Recommendations

We recommended that the board:

- undertake an independent nursing review of pain monitoring and assessment by nursing staff in the relevant wards;
- highlight the findings of this investigation with the staff involved, particularly in relation to the impact of an earlier x-ray and subsequent complaints handling; and
- apologise to Mrs C for the failures in Mrs A's care and treatment identified in our investigation, and for her time and effort in pursuing this complaint.