SPSO decision report

Case: **201302154, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained that there was a failure to provide his elderly mother (Mrs A) with appropriate care and treatment during two hospital admissions. Mrs A was first admitted to University Hospital Crosshouse when she fractured her pelvis after a fall at home. Mr C complained about the length of time his mother spent in the emergency department before being transferred to a ward. He also complained that her medication was changed and that she was discharged to a rehabilitation centre suffering from severe jaundice.

After taking independent advice from one of our medical advisers and our nursing adviser, we found that the time taken by medical staff to assess Mrs A and admit her to a ward was reasonable, and we identified no failings in nursing care. There was not enough evidence for us to say whether her medication was changed but we were satisfied that there was no evidence that when Mrs A was transferred to the rehabilitation centre she was suffering from severe jaundice. However, we were concerned that Mrs A did not appear to have been reviewed by a consultant within 24 hours of admission. Although our adviser said that such an assessment would not have altered the outcome for Mrs A, we considered this to be a failure of care. We were also concerned that there was a failure to assess Mrs A's bone health for possible osteoporosis (a condition that affects the bones, causing them to become fragile and more likely to break) and the reasons why she fell and suffered a fracture. In view of these failures we decided that the board failed to provide appropriate care and treatment to Mrs A during her admission.

Mrs A was readmitted to University Hospital Crosshouse the following month because her sodium level was low and she had a slow pulse. Mr C complained that medication prescribed prior to admission was changed, and that when she was transferred to Ayrshire Central Hospital she received poor nursing care.

Our medical adviser explained that there were sound medical reasons why Mrs A's medication was changed, and our nursing adviser found no evidence of any failings in Mrs A's nursing care while she was a patient in Ayrshire Central Hospital. There had been issues in relation to Mrs A's clothing, but the board had already apologised for this and taken action to address the failings identified. We were, therefore, satisfied that the board dealt with this appropriately. However, we had a number of other concerns about Mrs A's care and treatment during this admission. There was insufficient documentation in her medical notes to suggest that the assessment of her condition was sufficiently detailed and her condition severe enough to merit the medication she was prescribed for vertigo (the sensation a person has that they, or the environment around them, is moving or spinning). Also, we did not find evidence that medical staff had discussed or explained the diagnosis of vertigo or the changes to medication with her, or with Mr C. We also found that Mrs A's GP was only given a very basic level of information about her condition and treatment, with no information about her sodium level at the time of discharge or the changes to her medication. Finally, we considered that Mrs A's medical notes for this period were difficult to interpret because of poor handwriting. Because of all these issues, we found that aspects of Mrs A's care and treatment fell below a standard that could reasonably have been expected, and we upheld this complaint too.

Recommendations

We recommended that the board:

- apologise to Mr C and to Mrs A for the failings identified;
- ensure there is appropriate consultant assessment, including at weekends, for patients admitted as an orthopaedic emergency in University Hospital Crosshouse;
- ensure that the reasons why a patient has sustained a fall and the consequences of the fall are both assessed;
- ensure that medication changes are discussed as appropriate with the patient or, where appropriate, a patient's carer prior to their discharge;
- ensure that a patient's discharge summary contains all relevant information; and
- remind staff of the need to ensure that entries in a patient's records are legible.