SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201305714, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, action taken by body to remedy, recommendations

Summary

Mr C said that, as a result of having been left too long on a hospital trolley in an x-ray department, he developed a pressure sore which was still causing him considerable problems. He explained that he is tetraplegic (paralysis or restricted movement in all four limbs as a result of spinal damage) and that as a result, extra care should have been taken to ensure that he was not lying in the same position for a long time.

In response to his complaint the board had immediately acknowledged that the delay in returning Mr C to the ward was unacceptable and apologised for the distress and inconvenience the incident had evidently caused him. They noted that there was no information from the ward highlighting that he was tetraplegic and that the ward escort had not made staff in the department aware of Mr C's situation. The board said they were taking forward an awareness programme for all clinical staff in the imaging department to identify patients at risk of developing a pressure ulcer, but that this required the patient's pressure ulcer status to be provided by the ward.

We decided that further investigation was not required and upheld Mr C's complaint without asking the board for further information. We made recommendations to the board reflecting not only Mr C's complaint about his care, but also seeking to remedy the injustice we consider resulted from the board's failure to take steps to prevent him developing the pressure sore.

Recommendations

We recommended that the board:

- review, and revise if necessary, the process within wards for giving instruction for the extra care of patients assessed as being at risk of developing pressure sores who are being moved by trolley to other departments;
- consider whether it would be appropriate for the board to assist with the cost of home care in view of the failings identified;
- advise the Ombudsman of the outcome of their considerations on assisting with the cost of home care; and
- apologise to Mr C for the poor communication between the ward and the imaging department that led ultimately to him developing a pressure sore.