SPSO decision report

Case: **201401085, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care provided to her late mother (Mrs A) by Forth Valley Royal Hospital. Mrs A had dementia and was admitted to the hospital suffering from a urinary tract infection and increased confusion; she was noted to be generally unwell. One evening, Mrs A fell out of bed just before 21:00 but Mrs C was not told about this until the following morning.

Mrs A had been reviewed by a doctor and her head and shoulder were x-rayed, but despite having pain in her leg this was not x-rayed. Three days later, after Mrs C pointed out to nursing staff that Mrs A's foot was at an odd angle and she was in severe pain, an x-ray was done and it was found that Mrs A had broken her hip. Remedial surgery was considered but due to Mrs A's on-going and recurrent infection and her general frailty, it was agreed with the family that only palliative (end of life) care was appropriate. Mrs A died less than a fortnight after her fall.

Our investigation included taking independent medical advice from two of our advisers, a doctor specialising in care of the elderly and a senior nurse. The advisers found some evidence of reasonable care, especially in Mrs A's initial care - but they were critical of the lack of communication with Mrs C about Mrs A's fall and later about what happens when a patient dies in hospital; the delay in diagnosing Mrs A's broken hip; that at one time Mrs A's notes were missing and later found in another patient's room - resulting in a delay in prescribing pain relief for Mrs A; and that when surgery was still being considered, Mrs A was found to have an incorrect identification wristband on.

Recommendations

We recommended that the board:

- ensure that all staff involved in this complaint are made aware of our findings and reflect on them to inform their future practice;
- consider the introduction of an information leaflet for relatives explaining the procedure when a patient dies in hospital;
- remind staff involved in this complaint of the requirements of the General Medical Council and Nursing and Midwifery Council guidance on record-keeping, and in particular with regard to protecting patients' confidential information;
- ensure that staff involved in this complaint are reminded of the importance of good, and timely, communication with relatives where patients have sustained a fall and/or injury while in hospital; and
- issue a written apology for the failings identified during this investigation.