SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201405636, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care her relative (Mrs A) received at Forth Valley Royal Hospital. Mrs A was admitted with severe abdominal pain but on her first night in hospital, she suffered a fall. An x-ray was taken but clinicians caring for Mrs A did not identify any fracture after reviewing the image. The x-ray was subsequently reviewed by a radiologist (a doctor specialising in medical imaging) who reported that there was a suspicion of fracture to the pelvis. This report was not acted on for over a week, during which time staff continued to try to mobilise Mrs A. A subsequent scan showed that Mrs A had sustained multiple fractures.

When Mrs C complained to the board, the first response she received included a number of factual inaccuracies including that Mrs A had been admitted to hospital following a fall at home. A later response apologised for these errors. Mrs C remained dissatisfied and asked that we consider her complaints that there was an unreasonable delay in identifying Mrs A's fracture and that she had been unreasonably mobilised.

After taking independent advice from a consultant geriatrician, we upheld Mrs C's complaints about the medical care Mrs A received. The adviser considered it unreasonable that the x-ray report indicating that there was a suspicion of fracture had not been acted on and said it appeared staff caring for Mrs A had wrongly assumed the initial opinion that there was no fracture was correct. We found no evidence that Mrs A had been inappropriately mobilised after her fractures were identified but, in light of the fact that attempts were made to do so prior to this, we upheld Mrs C's complaint on this issue. We also upheld Mrs C's concerns about complaints handling as it is vital that complaint responses are factually accurate. While the board have already apologised for this matter, we found that they had not referred to the delay in acting on the

x-ray report in their response, which we did not consider to be reasonable.

Recommendations

We recommended that the board:

- ensure that our findings are brought to the attention of the staff involved in Mrs A's care and treatment. This should include the adviser's comments on communication and the falls risk assessment;
- provide evidence that they have considered how to prevent the problem in relation to the result of the x-ray not being taken into account from recurring in the future; and
- provide a further apology to Mrs C for the complaints handling issue identified in this investigation.