SPSO decision report

Case: **201407064, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C, who works for a voluntary agency, complained about the care and treatment that her client (Mrs A) had received during admissions to the Southern General Hospital, the Victoria Infirmary and the New Victoria Infirmary. Mrs A was initially admitted after a fall where she broke her arm and leg. Whilst Mrs A was in hospital, she suffered a series of falls, some of which resulted in further injury.

After taking independent advice from a nursing adviser, we did not uphold Mrs C's complaint that a fall Mrs A had while using the toilet at the Southern General Hospital was caused by unreasonable circumstances. The advice we received was that it was appropriate for Mrs A to have been allowed privacy to use the facilities after being assisted there by nursing staff. Although we did not uphold this aspect of the complaint, we did make a recommendation about this.

We also took independent advice from a consultant physician and geriatrician who considered whether it was reasonable that staff at the New Victoria Infirmary had not identified a hip fracture following a fall there. We did not uphold this complaint as the advice we received was that there was no indication that, following the fall, Mrs A had sustained a fracture. The adviser also said that an appropriate medical assessment had taken place. We also did not uphold Mrs C's complaint that Mrs A had to wait too long for surgery following admission to the Victoria Infirmary. We found that surgery had taken place within the recognised standard of 48 hours.

We did, however, uphold a complaint about Mrs A's premature discharge from the New Victoria Infirmary. We found that records, including National Early Warning Scores (NEWS), were unavailable and it was not clear whether there had been a failure to complete these or if they had been lost. These records, had they been available, would have enabled the adviser to confirm whether the decision to discharge was reasonable.

We also found that nursing staff caring for Mrs A should have requested a medical review before she was discharged due to her recent falls history and the level of pain she was experiencing.

Recommendations

We recommended that the board:

- ensure that the relevant staff are made aware of the nursing adviser's comments on toilet supervision requirements and facilities checks;
- issue an apology for the failing to request a medical review prior to discharge;
- make the relevant staff aware of the nursing adviser's comments on requesting a medical review; and
- take steps to ensure NEWS scores are appropriately taken and recorded on the ward and that medical records are appropriately stored.