SPSO decision report

Case: **201507730, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Outcome: some upheld, recommendations

Summary

Miss C's mother (Mrs A) had cancer and was receiving care at home. During an admission to Glasgow Royal Infirmary for a review of her care, Mrs A suffered a fall. After her fall, Mrs A underwent a scan and was discharged two days later.

The scan report was issued six days after the scan took place and showed a fracture to Mrs A's L1 vertebra (a bone in the base of her spine). Miss C said that on Mrs A's discharge from hospital, Mrs A's family had been told that the scan was clear.

Mrs A's family continued to care for her at home but were concerned about her continuing back pain. They asked her GP to check the results of the scan with the hospital. Miss C said that the family was told that Mrs A had suffered a fracture to her L3 vertebra (a different bone in the base of the spine). Mrs A died the next day. Miss C was concerned that Mrs A had been cared for without her family being aware of her fracture.

Miss C complained to us that the family had not been reasonably informed about the results of the scan. We took independent advice from a consultant in general medicine and a radiologist. They noted that the fracture was clearly visible on the scan, but although the hospital's computerised audit trail showed staff had reviewed the scan, this was not documented in the medical records and there was no evidence that the results had been communicated to Mrs A or her family. While we did not find evidence that staff had given incorrect information to Mrs A or her GP, we were critical that staff did not identify the fracture and share this information. We therefore upheld this complaint.

Miss C also complained about the provision of Mrs A's pain relief during her admission. The advisers noted that staff had assessed and monitored Mrs A's pain appropriately and provided pain relief when required. We therefore did not uphold this aspect of Miss C's complaint.

Recommendations

We recommended that the board:

- apologise to Miss C's family for the failings found during our investigation;
- feed back our findings about the lack of documentation and communication of the scan results to the medical staff involved; and
- review and address any training needs for the staff involved, in relation to interpreting scans of this kind.