SPSO decision report

Case: **201908610, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained to us about the care and treatment provided to their parent (A). A was admitted to Inverclyde Royal Hospital after they had fallen at home. The following night, A had an unwitnessed fall in the hospital. Around ten days later, A's leg was noted to be at an odd angle and A was found to have a fractured hip.

C complained about the nursing care A received. We took independent advice from a nurse and an orthopaedic consultant (a specialist in the treatment of diseases and injuries of the musculoskeletal system).

We found that A's initial falls risk assessment was unreasonable and A's family was not informed about A's fall. We upheld this aspect of the complaint. However, we noted that the board had already taken action to address failings in nursing care they had identified.

C also complained about the medical care A received. We found that after A fell both at home and at the hospital, appropriate medical examinations were not carried out and/or documented. We found it was highly likely this led to a delay in identifying A's hip fracture and in treating it. We also found that when A had hip surgery, there was no record that the risks of general anaesthetic had been discussed with A or their family. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in A's nursing care (in relation to their initial falls risk assessment and their 'getting to know you board'); and the failings identified in A's medical care and treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Patients should be given clear information about the risks of general anaesthetic; and the discussion should be clearly recorded.
- Patients who have fallen should be given appropriate medical examinations, which are clearly documented.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.