

SPSO decision report



Case: 202003211, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care provided by the board to their parent (A) whilst admitted at Glasgow Royal Infirmary. A had been admitted with low blood iron levels and a two-week history of back pain, queried to be a spinal fracture of osteoporotic (weakened bones) or pathological (caused by a disease) origin. Following A's admission, they suffered a "controlled fall". Twelve days later, A complained of being unable to move their legs. An MRI scan of the spine was carried out, which confirmed that A had suffered a fractured vertebra causing spinal cord compression affecting A's ability to move their lower limbs and control bowel and bladder functions. A was subsequently treated conservatively due to their age and comorbidities.

C complained about the circumstances surrounding the fall A suffered and that staff had not recorded details of the incident under the Datix reporting system as required. C considered that A had sustained the spinal injury during this incident and that the lack of Datix report meant that there had been a delay in identifying the injury.

The board accepted that a Datix report had not been completed as required at the time of A's fall but that this had not prevented A from being assessed. The board also stated that a Datix report had been completed retrospectively and that the incident had been reviewed by the hospital falls team. The board stated that it was not believed that A's fall had caused the spinal fracture, which may have been present in advance of A's admission.

We took independent advice from consultants in emergency and general medicine. We found that despite A presenting to the A&E with a queried spinal fracture, no neurological examination was carried out nor was any consideration given to performing an X-ray of A's spine. This was unreasonable practice. In addition, the board's failure to complete a Datix record of the fall A suffered was also unreasonable although it was impossible to say with any certainty that this incident had caused A's spinal fracture.

We found that the board were unable to produce any evidence to show that a Datix record into A's fall had been completed retrospectively or that the incident had been reviewed by the hospital falls team.

In view of the above failings, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for unreasonably failing to carry out a neurological examination of A, for not considering whether an X-ray of A's spine was required following their presentation to the A&E at Glasgow Royal Infirmary and for providing inaccurate information in their complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

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

- In patients who present to A&E with new onset back pain, a neurological assessment should be performed as part of baseline medical examinations. Where the cause of new onset back pain in patients is suspected to be an osteoporotic or pathological fracture, consideration should be given to performing X-ray imaging to investigate the possibility. Any decision not to proceed with X-ray imaging, should be documented in the clinical records.

In relation to complaints handling, we recommended:

- The board should ensure that information provided in response to complaints is factually accurate and that, where the board has confirmed specific actions have been taken in response to a complaint, evidence of this can be provided.

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.