SPSO decision report

Case: **202008183, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to the board about the care and treatment provided to their late parent (A) regarding hip problems they suffered.

A was admitted to hospital with worsening mobility having suffered a number of recent falls. Under the care of older people's services they were reviewed by occupational therapy and received physiotherapy, before being moved to another hospital for rehabilitation. A month after being discharged, A was readmitted and underwent an X-ray CT scan. A was initially diagnosed with a broken femur. A underwent hip replacement surgery and passed away a month later.

C complained that despite being informed by the board that A had sustained a fracture of their right femur, possibly present some years prior, they were later told that A had not sustained a fracture. Nevertheless, A's death certificate had recorded a fracture of the right femur as one of the causes of death. This confusion caused the family significant anxiety. In their complaints response the board concluded that junior medical staff had been responsible for misdiagnosing A and apologised for the miscommunication. They also apologised for the misdiagnosis having been included on A's death certificate.

We took independent advice from a medical adviser with expertise in orthopaedics (treatment of diseases and injuries of the musculoskeletal system), and further advice from a radiologist (specialist in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans). We found that while A did not have a broken femur, the board had failed to act upon a CT scan taken some years previously that showed A was suffering from significant arthritis which therefore went untreated over the subsequent years. Additionally, the board had emphasised the role of a junior doctor in misdiagnosing the fractured femur despite the involvement of more senior management in signing off on this diagnosis. In view of these specific failings, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Care should be taken by staff to ensure that patient records are correct and as full as they can be. Where discussions have taken place what was said should be documented. A's case should have been discussed at the board's Radiology Events and Learning Meeting (REALM). If this had not happened they should happen in order to highlight the importance of reporting significant osteoarthritis as an incidental finding, if it has not been depicted on prior imaging.

- The board’s complaint handling monitoring and governance system should ensure that complaints are appropriately investigated and that failings (and good practice) are identified and learning from complaints are used to drive service development and improvement.

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.