SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201507492, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C complained about the care and treatment her mother (Mrs A) received from the Victoria Infirmary when Mrs A attended A&E following a fall. Mrs A was found to have a fractured arm and was admitted to the orthopaedic ward. Four days later, Mrs A was noted to be suffering from hip and leg pain and was found to have a hip fracture that required surgery. Mrs A was transferred to the New Victoria Hospital for rehabilitation, but due to concerns about her condition, was transferred back.

Miss C complained about an excessive delay in transferring Mrs A from a trolley in A&E to a ward. She also complained about Mrs A's medical treatment and nursing care, and that communication with Mrs A's family was poor.

We took independent advice from an A&E consultant, an orthopaedic consultant, a consultant physician, and a nursing adviser. We found that there was an unreasonable delay in Mrs A being transferred from a trolley to the ward, which the board had accepted and apologised for. We also identified an unreasonable delay in Mrs A's hip fracture being diagnosed and that her transfer to the New Victoria Hospital for rehabilitation was unreasonable as there was a lack of evidence to show that she was fit for discharge. We therefore upheld these aspects of Miss C's complaint. However, we found that the nursing care in terms of assessing and monitoring food and fluid intake was reasonable.

Finally, we were critical that there was poor communication with Mrs A's family by both the A&E staff and orthopaedic team, for which the board had apologised. While Mrs A's consent form for the surgery indicated that she was not able to give informed consent, we found no evidence of communication with Mrs A's family in this regard.

Recommendations

We recommended that the board:

- provide information about the action taken to minimise waiting times for patients in A&E before they are admitted to a ward;
- ensure that the A&E doctor involved in Mrs A's care reflects on the adviser's findings at their next appraisal to ensure appropriate clinical assessment takes place;
- ensure that the medical staff responsible for Mrs A's transfer reflect on the adviser's findings regarding fully documenting the reasons supporting a patient's discharge or transfer;
- apologise to Miss C for the failings identified with regard to the diagnosis of Mrs A's hip fracture and the decision to transfer Mrs A;
- remind relevant staff involved in Mrs A's care in A&E and the orthopaedic ward of the importance of communicating effectively with family members and documenting in the clinical records when this has been done; and
- review their consent process for patients who are deemed to lack capacity to ensure where relevant that

the views of relatives and carers are effectively taken into account.