SPSO decision report

Case: **201608947, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment that his father (Mr A) received at Perth Royal Infirmary following a fall. Mr C was concerned that a fracture was not identified until Mr A had been in hospital for eight days. Whilst in hospital, Mr A also suffered a period of delirium. Mr C complained about communication issues and the way that Mr A had been transferred between wards at the hospital. Finally, Mr C also considered that the board had not handled his complaint reasonably.

We took independent advice from an emergency department consultant, an acute care consultant and a nursing adviser. We found that there was no documentation of an examination of Mr A's neck in the emergency department. As the x-rays that were taken had been difficult to interpret, further action should have been taken to rule out fracture, or clear reasons should have been recorded for not doing this. We considered that there were opportunities to diagnose the fracture at an earlier stage. In regards to Mr A's delirium, we found that the care he received was reasonable, although there was some areas where practice could be improved.

In relation to communication issues and transfers within the hospital, we found that nursing notes indicated that Mr A was in pain but that this information did not appear to have been shared with medical staff. We also found that Mr C had not been kept properly updated regarding Mr A's moves within the hospital. We noted that Mr A's moves had been reasonable however, on one occasion, he was transferred during a meal which was inappropriate.

In relation to complaints handling, we found that the board had not addressed Mr C's concerns about the delay in diagnosing Mr A's fracture in their response and that Mr C was not kept appropriately updated during the complaints process.

We upheld all of Mr C's complaints. However, we noted that the board identified some failings in their consideration of this case and had apologised for these.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the delay in diagnosing the fracture; for not fully addressing his concerns; and for not keeping him updated during the complaint process. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Medical staff should keep comprehensive medical records.
- Where x-rays are inadequate, consideration should be given to further imaging or discussion with the on call radiologist. If this is not considered necessary, the rationale should be clearly documented in the

medical records.

- There should be a mechanism in place for nursing staff to make medical staff aware of issues with continuing pain. Consideration should be given to unitary records and reviewing how nursing/medical staff communicate during formal handovers.
- Consider the adoption of Health Improvement Scotland's 'Think Delirium' as a means to try to reduce delirium in hospital and manage it appropriately, particularly liaising with relatives.

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.