SPSO decision report

Case: **201703997, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment her late father (Mr A) received at Queen Elizabeth University Hospital. Mr A was admitted to hospital with a broken hip after falling at home and underwent an operation. Ms C complained about both the medical and nursing care Mr A received. The board acknowledged that there was an unreasonable delay in transferring Mr A to the orthopaedics (the specialty of medicine regardingconditions involving the musculoskeletal system) ward and identified failings in nursing care, which they apologised to Ms C for. Ms C was unhappy with this response and brought her complaint to us.

We took independent advice from a consultant orthopaedic and trauma surgeon (a specialist in diagnosing and treating a wide range of conditions of the musculoskeletal system) and from a registered nurse. We found that there was no unreasonable delay in carrying out Mr A's hip operation, as he needed treatment for other health issues to ensure he was fit for the operation. However, we considered that there was an unreasonable delay in transferring Mr A to the orthopaedic ward, which the board had accepted. Therefore, we upheld this aspect of Ms C's complaint.

In relation to the nursing care, we found that there was an unreasonable failure to communicate with Mr A's family about the risk of him developing delirium and that there was a delay in obtaining information about his likes/dislikes but we considered that reasonable steps were taken to minimise Mr A's risk of a fall. We also found that there was a failure to transfer all of his belongings with him when he moved to another ward but the board had subsequently found his belongings and returned them to Mr A's family. Finally, we noted that his bowel movements were not monitored and/or recorded appropriately. Therefore, we upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the failure to properly monitor and/or record Mr A's bowel movements. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Nursing staff should appropriately monitor and record patients' bowel movements, particularly after they have an operation.

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.