SPSO decision report

Case: **202301757, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) over two admissions to hospital. A attended the emergency department following a fall at home and was treated with painkillers for a pain in their neck. They were admitted to the ward for further monitoring of their fast and irregular heartbeat. A was reviewed the next morning and discharged that day. However, A returned to hospital later that day after another fall. A was reviewed and admitted to the ward where they were later diagnosed with a fracture of a bone in their neck.

C complained that the board failed to diagnose the fracture on the first admission to hospital and about the decision to discharge A. In response to the complaint, the board did not identify any failings with respect to assessment of A, but acknowledged that the communication of their diagnosis and discharge could have been better. With respect to the second admission, the board explained that symptoms of neck fracture are not straight forward and the examinations carried out within the emergency department were appropriate. C was dissatisfied with the response and brought their complaint to our office.

We took independent advice from an emergency medicine consultant and a consultant geriatrician (specialist in medicine of the elderly). In relation to A's first admission, we found that the initial assessment of A's condition in the emergency department was reasonable, although there was a missed opportunity for further assessment before A went to the ward. However, the examination and assessment of A's neck pain on the ward was unreasonable, as was the assessment of A's suitability for discharge, given the failure to properly assess A's neck injury, mobility, and cognitive function. We found that the board failed to provide A with appropriate care and treatment during their first admission and upheld this part of C's complaint.

In relation to A's second admission, we found that A's neurological examination did not include a cervical spine assessment. The board acknowledged in their correspondence with our office that the care provided at this time was not to an acceptable standard. Therefore, we determined that the care provided in the emergency department was unreasonable. We found that the care and assessment provided during A's admission to the ward was reasonable, and there was no delay in arranging further investigations. Given our findings in respect to the care provided in the emergency department, we upheld C's complaint regarding A's second admission to hospital.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for the failures 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:

- Clinical staff should be familiar with relevant NICE guidelines on the management of suspected cervical

fractures. Relevant departments concerned should review their practices regarding the assessment of pain and investigation of potential head/neck injury.
- Patients should only be discharged following appropriate review and assessment of all clinical factors relevant to the decision to discharge a patient from hospital.

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.