SPSO decision report

Case: **201100772, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment;diagnosis
Outcome: some upheld, action taken by body to remedy, recommendations

Summary

Mrs C complained about the hospital treatment provided to her late father (Mr A) who had chronic obstructive pulmonary disease. Mr A became ill at home and was admitted to Glasgow Royal Infirmary suffering from pneumonia. He died in hospital ten days later.

Mrs C complained that attention was not paid to Mr A's nutritional needs and that she 'constantly' asked staff to tube-feed her father but that this was not done. She also complained that staff decided that Mr A was not to be resuscitated if his breathing or heart failed, but that this decision was not discussed or agreed with the family. She said that the family were not made aware of the seriousness of Mr A's condition and that although Mr A died at 09:40, the time of death was not certified until 10:30 and in that time the doctor did not approach or attend to Mr A in any way.

We took advice from one of our medical advisers. This established that Mr A's clinical treatment was appropriate and that as his nutrition and hydration were appropriately maintained, a naso-gastric tube was not necessary. We found, however, that there had been failures in communication. One of the board's doctors said he had told a family member that Mr A's death was imminent, but could not remember to whom he had spoken. The family, on the other hand, said they were not aware how serious Mr A's condition was. They were shocked when he died, and concerned that staff did not attend when that happened. From a staff perspective, Mr A did not have long to live and, believing that his family knew this, staff had left them to spend the last moments alone with him. Our adviser, however, commented that he would be concerned if a doctor did not – even briefly – establish that death had actually occurred and confirm this to the family. All of this shows that the family and staff had different understandings of the seriousness of Mr A's condition. The problem was caused by a breakdown in communication and a lack of documentation of what was actually said and to whom. The board had already apologised for the

communication failure and drawn up an action plan to address this for the future. As a result of what we found in our investigation, however, we recommended that they add to it.

Recommendation

We recommended that the board:

- review their action plan to include information about how nurses and medical staff deal with the difficult issue of who informs relatives of the presence of a Do Not Resuscitate form (if appropriate) and about communication when a patient is gravely ill and at the point of death.