SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201201876, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Mrs C was unhappy with the medical treatment and nursing care that her late mother (Mrs A) received in hospital over a two-month period. Mrs A was admitted to hospital with a fractured leg and suspected heart attack after a fall at home. Mrs A had an operation shortly after her admission. Unfortunately, her condition continued to deteriorate and she died several weeks later. Mrs A had previously had two liver transplants because of liver disease, and Mrs C said that there was an unreasonable delay by the hospital clinicians in contacting the transplant unit at another hospital for advice. She also questioned whether appropriate medication was provided and whether Mrs A's increasing confusion was addressed properly. In relation to nursing care, Mrs C said there was a failure to prevent Mrs A falling from her bed and in seeking medical attention when her condition deteriorated. Mrs C and her family were also distressed by the manner in which staff treated them about obtaining Mrs A's death certificate.

The advice we accepted was that despite appropriate surgical and medical management, Mrs A's liver started to fail following surgery. As she was not suitable for a further liver transplant, unfortunately her death was unavoidable. Furthermore, although the medical adviser considered that the transplant unit should have been contacted earlier this did not have any bearing on the eventual outcome. Having said that, we also found that there were failings by clinical staff in relation to record-keeping and in their communications with Mrs C and her family which, understandably at such a difficult time for them, caused distress. The medical adviser said, however, that these did not have any adverse effect on Mrs A's clinical treatment or outcome. Nonetheless, we were concerned about the failures given the seriousness of Mrs A's condition, in particular the failure relating to record-keeping which does not show that appropriate medical assessments were carried out over four days following her admission and operation. Therefore, we found that staff at the hospital failed to provide Mrs A with an appropriate level of clinical treatment.

Having carefully reviewed all of the evidence and the advice received from the nursing adviser, we were unable to establish exactly what happened in relation to nursing care and attitude, due both to a lack of evidence and the differing accounts of those involved. The board apologised for specific issues raised about staff attitude, and accepted there was a failure to provide Mrs C with the appropriate information booklet following Mrs A's death. In relation to Mrs A's fall, the nursing adviser said that the care plan and assessment that did not put Mrs A at high risk of falls was appropriate. Taking account of all of the evidence, we did not find that nursing staff failed to provide Mrs A with an appropriate standard of nursing care and treatment.

Recommendations

We recommended that the board:

- ensure timely referrals to all appropriate specialists where a patient has complex medical conditions (transplant patients in particular) so the specialists are involved early in the patient's treatment;
- review how clinical staff communicate with a patient's family and share our medical adviser's comments with them;

- act on the comments of our medical adviser in relation to poor record-keeping and share those comments with the appropriate staff;
- ensure that appropriate medical assessments are carried out on the ward and are documented; and
- apologise to Mrs C and her family for the failings identified in our investigation in relation to poor communication and record-keeping.