SPSO decision report

Case: **201403869, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Miss C's father (Mr A) was admitted to Glasgow Royal Infirmary from another hospital where he had been admitted earlier following a fall at home. Mr A was admitted to A&E and then moved to a ward. Mr A died several days after his admission.

Miss C was concerned that many mistakes and problems had occurred during Mr A's admission to Glasgow Royal Infirmary. Miss C met with the board who accepted there had been a number of failures in Mr A's care and treatment, and offered apologies for these. They also shared information with Miss C about actions taken to discuss failings identified with staff, and the procedures put in place to help avoid any repeat for other patients in the future. Miss C, however, remained concerned.

We took independent advice from a medical adviser and a nursing adviser.

Our medical adviser said that on admission, Mr A was noted to have had a fall, underlying liver disease, vomiting and diarrhoea, and a new acute kidney injury. Our medical adviser said that Mr A's medical records were comprehensive and that, overall, his care was of a good standard. However, our medical adviser also said there was a failure to prescribe continuous fluids, and to record and monitor Mr A's fluid balance which, in a patient with vomiting and diarrhoea and a diagnosis of acute kidney injury, were serious failings.

Our nursing adviser said that, overall, Mr A's nursing records and charts were of a good standard and there was a reasonable level of communication with Mr A's family. However, she also considered there was a serious failure in the recording and monitoring of Mr A's fluids by nursing staff. Therefore, Mr A's nursing care had fallen short of the expected standard in relation to the recording and monitoring of his fluid balance.

Recommendations

We recommended that the board:

- provide evidence of policies for fluid balance documentation and of compliance with such policies for the A&E department and the ward involved in this case at Glasgow Royal Infirmary.