SPSO decision report

Case: **201407746, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care and treatment given to her late mother (Mrs A) during an admission to the Royal Alexandra Hospital. She said that staff at the hospital delayed in attending to Mrs A and in providing her with treatment, and that she was given too much fluid intravenously. Mrs C believed this all contributed to Mrs A's death. Mrs C also complained that there were delays in transferring Mrs A to a treatment ward which she said was also to her detriment.

We took independent advice from a consultant in emergency medicine and we found that while Mrs A had been assessed in the emergency department as an urgent case to be seen within an hour, she was not seen until after two hours of arrival on the ward. It also took 11 hours to transfer her to a ward for treatment which was far too long for someone who was sick, elderly and frail. Furthermore, Mrs A had been given a litre of saline solution which was too aggressive given that she was known to have pre-existing heart disease. For these reasons, we upheld the complaint. However, there was no evidence to suggest that the failures identified had contributed to Mrs A's death.

Recommendations

We recommended that the board:

- make a formal apology to Mrs C recognising the shortcomings identified;
- satisfy themselves that such delays in the emergency department could not happen again and advise us of the processes since put in place to avoid this; and
- ensure that our findings are brought to the attention of the doctors and staff in the emergency department for them to consider further.