SPSO decision report

Case: **201508084, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: not upheld, no recommendations

Summary

Ms C, who works for an advice and support agency, complained on behalf of her client (Ms B) who had concerns about the care and treatment received by her mother (Mrs A) at Gartnavel General Hospital. Mrs A was admitted to the hospital for rehabilitation and post-operation recovery following surgery to remove a tumour from her lung. Mrs A acquired a chest infection during her admission and suffered from vomiting and diarrhoea. Mrs A died while in the hospital.

Mrs A had been unable to swallow following surgery. Ms C said that Ms B had concerns about the way staff administered nutrition to Mrs A via a percutaneous endoscopic gastrostomy (PEG) tube (a tube that enters the stomach through a small incision in the abdomen). Ms C also expressed concern that staff had failed to update Ms B and communicate with her appropriately during Mrs A's admission. Ms C noted that Ms B considered that the board had not followed the DNACPR (do not attempt cardiopulmonary resuscitation) policy in relation to Mrs A. Ms C also said that Ms B was concerned that staff had failed to manage the risk of diarrhoea and vomiting on the ward.

We took independent nursing advice. The adviser found no evidence in the medical records that staff had failed to provide Mrs A with appropriate PEG tube care and treatment. They also considered that the records showed that staff had communicated reasonably with Ms B. The adviser also found that staff had followed DNACPR policy appropriately and noted evidence of a discussion with Mrs A and completion of a DNACPR form. Regarding the management of diarrhoea and vomiting, the adviser was satisfied that the board had appropriate procedures in place and that nursing staff had acted reasonably in accordance with these. We therefore did not uphold Ms C's complaints.