SPSO decision report



Case:201508305, Greater Glasgow and Clyde NHS BoardSector:healthSubject:clinical treatment / diagnosisOutcome:not upheld, recommendations

Summary

Miss C complained about the care and treatment provided to her mother (Mrs A) at Glasgow Royal Infirmary. Mrs A had a complex medical history and was admitted to hospital for a blood transfusion. Her condition deteriorated and she remained in hospital, where she died six weeks later.

Miss C believed there was an unreasonable delay in establishing the source of an infection contracted by Mrs A and in the treatment of it, and that the cause of death was related to the infection and not to diabetes or heart disease.

We took independent advice from a specialist in kidney diseases. We found that appropriate investigations were carried out within a reasonable time and treatment decisions (particularly in relation to the prescription of antibiotics) were reasonable, including a decision not to resuscitate. We noted that Mrs A was very unwell on admission and the subsequent infection at the site of an intravenous cannula (a tube inserted into a vein, often to deliver medication) was in addition to a background of significant chronic medical conditions. We found that medical staff failed to communicate this and its implications in a reasonable way to Mrs A's family and made a recommendation to address this. We found no failings in the medical treatment provided to Mrs A and therefore did not uphold Miss C's complaint. However, while the infection at the site of the cannula was a recognised complication of the procedure Mrs A underwent, we made a recommendation in relation to policy regarding the insertion and care of intravenous cannulas.

Recommendations

We recommended that the board:

- provide us with an action plan to address the failings in communication highlighted in this investigation and ensure no recurrence;
- provide evidence that appropriate governance arrangements are in place to minimise the risks of an infection at the site of intravenous cannulas; and
- apologise for the failures this investigation identified.