SPSO decision report

Case: **201609720, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her mother (Mrs A) at Queen Elizabeth University Hospital. Mrs A was admitted to hospital with an infection in her knee. During the admission, Mrs A sustained an injury to her calf area whilst nursing staff were moving her to sit on the side of the bed. The day following the injury, a doctor inaccurately informed one of Mrs A's daughters that the injury was the result of a fall. Over the following days, Mrs A's condition deteriorated and she died.

Mrs C raised concern that nursing staff did not take appropriate steps to prevent her mother from sustaining an injury. We found that the board had completed an incident report for the injury which noted that Mrs A's skin was very fragile and concluded that nursing staff had provided appropriate care such that the injury was unavoidable. We took independent advice from a nursing adviser. We were satisfied that appropriate falls risk assessments had been carried out during the admission and we considered that the actions of nursing staff were reasonable and in keeping with the board's moving and handling policy. The nursing adviser agreed with the conclusion of the board's incident report, and we were unable to conclude that nursing staff failed to take appropriate steps to prevent the injury. We did not uphold this aspect of Mrs C's complaint.

Mrs C also raised concern about the way staff communicated with the family about the injury and the level of information provided about Mrs A's condition over the following days prior to her death. We took independent advice from the nursing adviser, as well as an adviser in general medicine. We found that the family were not told about the injury until the following day. The board said that this was because Mrs A wished to tell her family of the injury herself, yet we did not find evidence that Mrs A had stated this. When one of Mrs A's daughters was contacted, we found that a doctor provided inaccurate information about what had happened to Mrs A. We found that this should not have happened given that the injury was documented accurately in the nursing notes.

We also considered that there was evidence of a delay in recognising and responding to a deterioration in Mrs A's condition. The medical adviser was unable to conclude that Mrs A would have survived her illness if she received better care, however they did consider that the care was unreasonable. The medical adviser noted that the family did not seem prepared for Mrs A's death. The medical adviser was satisfied that the consultant did try to communicate that Mrs A might deteriorate further and that death was a possibility, but found that they may not have been quite explicit or clear enough when doing so. On balance, we upheld Mrs C's complaint about communication.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and her family for failing to immediately inform the family that Mrs A had sustained an injury and for the delay in recognising and responding to a deterioration in Mrs A's condition. The apology should meet the standards set out in the SPSO guidelines on apology available at: https://www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- In a similar situation staff should promptly contact family members or significant others (as appropriate), in line with the protocol for informing next of kin when a serious incident occurs. If a patient states that they wish to inform their family of an incident themselves, this should be documented in the records.
- Medical staff should be aware of information documented in the nursing records when providing patients and their families with information about their condition.
- Staff should ensure that deteriorations are recognised promptly and should be aware of how to respond.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.