SPSO decision report

Case: **201700886, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C, a patient adviser, complained on behalf of his client (Ms B) regarding the care and treatment provided to her father (Mr A) at Western Infirmary.

Mr A was an in-patient receiving dialysis (a form of treatment that replicates many of the kidney's functions) at the hospital for 12 weeks before he died. Ms B was concerned that Mr A did not receive appropriate dialysis treatment during the admission. We took independent advice from a consultant nephrologist (a specialist in kidney care and treating diseases of the kidneys). They noted that the delivery of dialysis was difficult in this case because Mr A was frequently confused and unable to co-operate with the dialysis treatment. We considered that the records showed that Mr A received a reasonable number of dialysis sessions during the admission, and that the dialysis treatment prevented the toxins in his blood from reaching excessive levels. We found no evidence of failings in dialysis treatment, and we did not uphold this aspect of Mr C's complaint.

Ms B was also concerned that the board failed to take appropriate steps to ensure Mr A was comfortable and safe when receiving dialysis treatment. We took independent advice from a consultant in old age psychiatry and from a registered nurse. We considered that medical staff appropriately managed Mr A's delirium with the input from the hospital's old age psychiatry team. We found that the board had taken reasonable steps to help to ensure Mr A was comfortable when receiving dialysis and we noted that a number of fall risk assessments were carried out throughout the admission. The records showed that Mr A sustained a number of falls during the admission, and we were unable to conclude that the board followed their referral criteria for the hospital falls prevention co-ordinator. Although we were unable to conclude that earlier involvement from the hospital falls prevention co-ordinator would have prevented Mr A's third fall, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms B for the delay in referring Mr A to the hospital falls prevention co-ordinator. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/leaflets-and-guidance.

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

- Patients at risk of sustaining a fall in hospital should be referred to the hospital falls prevention co-ordinator if they meet the board's referral criteria.