SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201705013, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the medical and nursing care and treatment provided to her late mother (Mrs A) at Royal Alexandra Hospital. Mrs A was admitted to the hospital from her nursing home and was treated for a urinary tract infection. She was discharged home, but returned to hospital a few days later. A scan showed that Mrs A had suffered a brain haemorrhage (bleed in the brain) and she was started on end-of-life care. About a week later, nurses noticed bruising on Mrs A's hip, and she was found to have suffered a hip fracture. Mrs A continued on end of life care for about three weeks before she died in hospital.

Mrs C felt that doctors did not treat Mrs A immediately when she first attended hospital, and she was unhappy that staff had instead asked the family what level of treatment they would prefer for Mrs A. Mrs C also felt that Mrs A was discharged too early. Mrs C raised concerns about the hip fracture; querying how this could have happened and why it was not discovered earlier by staff. Finally, Mrs C was concerned that Mrs A was kept on end-of-life care for an extended period of time without fluids or sustenance.

We took independent advice from a consultant in general medicine and from a nurse. We considered that it was appropriate for staff to discuss the level of treatment the family wanted for Mrs A when she was first admitted, and that this did not impact on the promptness or thoroughness of her treatment. We also did not find failings in the end-of-life care.

However, we found that staff had failed to establish Mrs A's normal level of functioning (known as baseline level of health) and therefore failed to adequately investigate her deterioration before discharging her. We found that staff should have done more to find out Mrs A's baseline level of health and that this may have alerted them to the fact that she was not back to normal when she was discharged.

We also found that Mrs A had been discharged without thickened liquids that had been prescribed.

Whilst we noted that the board had apologised for the hip fracture, which had probably occurred in the hospital, we found that they had not investigated the cause of the unexplained fracture at the time it was reported.

We upheld Mrs C's complaints about the medical and nursing care provided to Mrs A.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to establish Mrs A's baseline level of functioning and for failing to adequately investigate her deterioration. Also apologise for discharging Mrs A without the thickened liquids prescribed to her and for failing to promptly investigate the cause of Mrs A's hip fracture. 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:

- Where a patient is unable to communicate, staff should clearly document their normal level of functioning, based on information from their family and/or carers.
- Prescribed dietary products should be provided on discharge or available within a few hours.

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.