SPSO decision report

Case: **202104888, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Hygiene / cleanliness / infection control
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received from the board following A's admission to hospital having suffered a stroke. A developed COVID-19 symptoms and this was confirmed by a positive swab. A's condition deteriorated with them developing COVID-19 pneumonia and they sadly died.

C complained to the board about their parent contracting COVID-19, which they felt must have been hospital acquired as A was shielding prior to admission. C complained that A was unnecessarily transferred between wards which increased the risk of exposure to the virus. C reported concerns that there were known COVID-19 cases in a neighbouring ward and possibly within A's ward. C was concerned that A wasn't offered the opportunity of home rehabilitation.

The board's response stated that national infection prevention and control guidance for COVID-19 was followed at all times. They advised that it wasn't always possible to accommodate all shielding patients in a single room. They advised that A was transferred between wards according to their care needs. They said that they could not meet A's rehabilitation needs at home due to capacity issues with their community stroke team.

We took independent clinical advice from a nursing adviser specialising in infection control. We found that A required inpatient care to ensure that they received appropriate investigations and treatment for their suspected stroke. We found that the care provided to A in treatment for their stroke was reasonable and in keeping with their diagnosis.

We found that the board did not comply with relevant guidance on COVID-19 by failing to document the assessment of A's COVID-19 risk pathway during their admission. We found that there was an unreasonable delay in isolating A from the other patients once A's diagnosis of COVID-19 was suspected. Given these failings, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to triage A's level of risk, for failure to document A's shielding status and failure to isolate and follow airborne precautions from the point at which COVID-19 was suspected. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Feedback the findings of this investigation to relevant staff for reflection and learning, and to inform future practice.
- Medical records should contain all relevant information including the outcomes of assessments and the

information required to clarify the decision making regarding the delivery of care.

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.