SPSO decision report

Case: **201100377, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Miss C's mother (Mrs A) was admitted to hospital for surgery. Her recovery took a long time and she developed pleural effusions (fluid that gathers around the outside of the lung). After about four months she was transferred to another hospital. At this time she was still very unwell, being tube-fed and having a urinary catheter (a thin tube used to drain and collect urine from the bladder). Tests showed abnormalities in her abdomen. At the end of that month, Mrs A was transferred to a third hospital but returned to the second hospital several days later when tests indicated a chest infection. She was diagnosed as having contracted clostridium difficile (a common healthcare-associated infection). A line to provide better access to her veins for intravenous fluids and antibiotics was inserted but became dislodged. Her condition continued to worsen and she died a few days after being transferred.

Miss C complained that during her mother's time in the second hospital the board did not reasonably attempt to address her chest condition, and failed to help with eating or to consider her dietary requirements. She also complained that the board inappropriately transferred Mrs A to the third hospital, given her chest condition, and that they failed to take reasonable steps to ensure that the access line did not become dislodged. Finally, Miss C complained about the board's complaints handling.

We took independent advice from a medical adviser and a nursing adviser. The medical adviser said that before Mrs A's transfer to the third hospital there were shortcomings in diagnosing and managing the inflammation that Mrs A had and that the decision to transfer her was, therefore, questionable. The nursing adviser said that the nursing care in relation to nutrition was reasonable. However, given our concerns about the shortcomings in medical care we upheld the complaint. We were satisfied that in their complaint response the board provided a reasonable explanation for the cause of Mrs A's pleural effusions. However, we upheld the complaint about this because although they acknowledged that Mrs A's care could have been better managed, they failed to provide any further details. We also noted that they did not respond to her second letter of complaint for 14 weeks.

Recommendations

We recommended that the board:

- ensure that the failures identified are raised with the relevant clinicians during their next appraisal;
- review their complaints handling process in light of our findings; and
- apologise to Miss C for the failures identified.