SPSO decision report

Case: **201204887, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that her mother (Mrs A) received in the Glasgow Western Infirmary. Mrs A was admitted to hospital after a fall at home. She was treated for a chest infection, but tests found that she also had a cancerous tumour on her lung which had spread to her liver. Clinical staff decided that active treatment for this was not appropriate and that palliative care (care provided solely to prevent or relieve suffering) should be provided. Although discussions took place around potential discharge options for Mrs A, her condition deteriorated and she died in the hospital within two weeks of her admission. Mrs C complained about the nursing care that Mrs A received, discharge planning, nutrition and hydration and communication from staff.

We took independent advice on this case from a medical adviser and a nursing adviser. The clinical records indicated that Mrs A had varying levels of confusion throughout her admission, which made it difficult for staff to assess the extent to which she could consent to treatment or take part in discussions about her care. Generally we were satisfied that Mrs A's formal consent was not needed for the tests that she underwent, and we found that staff clearly recorded information about her preferences in terms of discharge arrangements and what she wanted to know about her diagnosis. We found that Mrs A's wishes about this were ultimately respected, and that all of the clinical treatment she received was appropriate. However, we were critical of some aspects of her nursing care. We found that staff failed to properly assess what additional support Mrs A might have needed during her admission. Mrs A had experienced problems early in her admission and we found that staff later kept drinks and snacks out of her reach to avoid spillages, rather than providing suitable utensils to help her eat and drink when she wished. We took the view that help with this might have made her time in hospital more comfortable, and that failure to provide this was poor practice. Overall, we found that the board failed to take adequate account of Mrs A's specific personal needs and upheld this complaint. We also upheld Mrs C's complaint that the board's responses to her formal complaints were unreasonably delayed.

We did not, however, uphold Mrs C's complaint about communication. Although we recognised that she was unhappy with the level and quality of communication from staff, we generally found this to have been reasonable. That said, we were critical of the board for failing to provide a private room for discussions about Mrs A's diagnosis.

Recommendations

We recommended that the board:

- apologise to Mrs C for the issues highlighted in our investigation;
- provide us with up-to-date details of the action they have taken to improve nursing staff's compliance with completion of patient admission and assessment documentation, including the provision of suitable utensils for patients with special needs;
- remind relevant staff of their responsibilities in obtaining patient consent to discuss care and treatment with family members;
- apologise to Mrs C for their poor handling of her complaint; and

- take steps to ensure their investigations and responses are not unreasonably delayed.