SPSO decision report

Case: **201302883, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment that his late wife (Mrs C) received over a four-year period. Mrs C suffered from haemochromatosis (a condition where the body absorbs an excessive amount of iron which is then deposited in organs, mainly the liver) and had cirrhosis of the liver as a result. She also had a number of other medical conditions. Mrs C died in 2012.

Mrs C had been an out-patient at a liver clinic at Gartnavel Hospital since 2009. Mr C was concerned about a number of issues, including that medical staff had not sufficiently considered causes other than alcohol as the reason for his wife's liver condition and had not considered her need for a liver transplant. He also said that Mrs C's consultant gastroenterologist (a doctor specialising in the treatment of conditions affecting the liver, intestine and pancreas) had never warned Mr and Mrs C about the seriousness of her condition and her prognosis (forecast of the likely outcome). We took independent advice from one of our medical advisers, who is a consultant in gastroenterology and hepatology (liver disease). The adviser said that Mrs C's medical records showed that she had asked to be seen at the liver clinic less often. Her doctors had agreed to this because she was also regularly attending a specialist hepatology clinic. The adviser said that Mrs C had not been a suitable candidate for a liver transplant at the time, and that it was appropriate for the consultant to have discussed with her whether alcohol was a contributing factor in her illness. The adviser found no evidence of a marked deterioration in Mrs C's condition while under review by the hospital. The available evidence did not show exactly what she was told, but having seen the medical records our adviser took the view that the potential severity of her condition would have been explained to her. Overall, we found no failings by medical staff in their care and treatment of Mrs C.

In 2012 Mrs C was admitted to the Royal Alexandra Hospital with shortness of breath and a pleural effusion (a collection of fluid next to the lung). She discharged herself six days later, as she and Mr C were unhappy with her care and treatment there. Among Mr C's concerns were that Mrs C was left unattended, particularly when she needed to use the toilet, and that nursing staff were unsupportive and had failed to treat skin sores. He also said that he was not told when Mrs C was transferred to another ward, and no-one could tell him where she had been moved to.

Our adviser said that the records showed that Mrs C was correctly diagnosed and that appropriate investigations were carried out after she was admitted. The adviser also said that it was appropriate, given Mrs C's liver condition, to have transferred her from an acute medical ward to a gastroenterology ward.

We obtained independent advice about the nursing care from our nursing adviser, who said that an entry in Mrs C's nursing notes on the day of admission gave the impression that a nurse lacked empathy towards Mrs C. The evidence also showed that Mrs C had fallen while on the ward and that nursing staff had not explored the reasons behind her fall or completed an incident form, which would have helped assess how the risk of further falls could be reduced. The nurse who completed the falls risk assessment form had also failed to record that Mrs C had fallen before, and the nursing admission assessment form wrongly said that she had no breathing problems and

was fully mobile and independent. There was evidence from the nursing records that nursing staff were communicating with Mr and Mrs C. There appeared, however, to be no system in place for recording information about transfers, which is why Mr C was unable to locate his wife when she was transferred between wards. As we found a number of failings in relation to Mrs C's nursing care in the Royal Alexandra Hospital, we upheld the complaint.

Recommendations

We recommended that the board:

- apologise to Mr C for the failings in respect of Mrs C's nursing care whilst she was a patient in the Royal Alexandra Hospital;
- ensure that the comments of our nursing adviser, in relation to communication and record-keeping, are shared with the nursing staff involved with Mrs C's care whilst she was a patient in the Royal Alexandra Hospital and provide evidence of this; and
- provide evidence that the Royal Alexandra Hospital has robust information systems in place in relation to inter-ward transfers.