SPSO decision report

Case: **201303065, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Ms C, who is an advice worker, complained on behalf of her client, Ms B. Ms B's late fiancé (Mr A) had died a few days after being admitted to Glasgow Royal Infirmary with severe jaundice. Ms B had told Ms C that the board provided inadequate nursing care, and that hospital staff failed to communicate adequately with Mr A's family, including about the severity of his condition, which she said caused Mr A and his family unnecessary distress and suffering. Ms C also complained about the board's complaints handling.

During our investigation, we reviewed Mr A's clinical records and took independent advice on his care from our nursing adviser. We found that at the heart of the complaint was Ms B's view that nursing staff acted insensitively towards Mr A. In cases where people are unhappy with the attitude of staff, it is often difficult to find evidence to support the complaint. This is not to say that we do not believe the accounts given; rather we find there are differing recollections, and often no independent evidence of behaviour or attitude. In Mr A's case, we could not reach a finding on whether nursing staff were insensitive.

Based on the evidence in the clinical records, we did not uphold the complaints about nursing care and communication. The records showed that Mr A was attended to regularly, and our adviser did not have any concerns about nursing care, noting that the board had since taken steps to support a person-centred care approach. The adviser also said the records showed that staff had tried to communicate the seriousness of Mr A's condition. The board had, however, acknowledged that some aspects of communication should have been better and had put improvement measures in place. In terms of how the complaints were handled, however, we upheld Ms C's complaint, as we found gaps in the records, and unreasonable delays in resolving the complaints.

Recommendations

We recommended that the board:

- reflect on staff's practice of introducing phone calls by saying 'do not worry', to determine whether they think it is appropriate as routine wording in all cases; and report back to the Ombudsman;
- ensure that, wherever possible, complaints (whether informal or not) are progressed in the absence of staff on sick leave;
- remind staff of the need to make records of informal complaints, in line with guidance; and
- ensure staff record when they tell complainants about the formal complaints process.