SPSO decision report

Case: **201305828, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mrs C complained on behalf of her mother (Mrs A) that staff at Inverclyde Royal Hospital provided inadequate care and treatment to her. Mrs C also complained that communication from hospital staff was not good enough. Mrs A had started taking antibiotics for a urinary tract infection two days before admission, and was admitted to the hospital with increasing confusion. Mrs C was particularly concerned about a fall her mother had in hospital, as well as treatment for Mrs A's confusion.

We received Mrs A's medical records from the board, and took independent advice from our nursing adviser. There was no dispute that Mrs A fell; what was disputed was the reason for the fall. In this case, we could not resolve the dispute given the differing accounts of what happened, although that did not mean we believed one version over another. In Mrs C's view, the fall was not addressed properly. The medical records showed that Mrs A was assessed after the fall, and no major injuries were found. Our adviser's view, which we accepted, was that the care provided to Mrs A was reasonable in the circumstances. Based on the available evidence, we concluded that hospital staff provided adequate care and treatment to Mrs A.

The board said they should have phoned Mrs C earlier to tell her about Mrs A's fall, and they apologised for this and reminded staff of the importance of keeping patients and relatives informed. We found evidence in the medical records that staff spoke to Mrs C regularly during Mrs A's stay in hospital, and that they were aware Mrs C was unhappy. Our adviser observed that staff could have tried to offer more support to Mrs C when she was visibly upset. However, we decided that, on balance, communication from hospital staff to Mrs C was adequate in the circumstances.

Although we did not uphold Mrs C's complaints, we made recommendations to address specific concerns raised by our adviser.

Recommendations

We recommended that the Board:

- reflect on this case, as part of ongoing improvements, to ensure that an appropriately detailed approach is taken to care planning to help manage delirium; and
- reflect on this case, as part of ongoing improvements, to ensure that staff provide support to relatives of patients with delirium.