SPSO decision report

Case: **201501805, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C's mother (Mrs A) received regular dialysis (a form of treatment that replicates many of the kidney's functions) at the Inverclyde Royal Hospital Renal Unit. During one session, Mrs A experienced some pain and bleeding and, shortly after this, nurses noticed a red scabbed area near the dialysis access. Two weeks later, Mrs A experienced a significant bleed from her dialysis access and required emergency surgery. Sadly, Mrs A suffered a heart attack shortly after the surgery and died.

Mrs C complained about the treatment provided by the dialysis unit, and in particular the decision not to refer Mrs A for medical review when the scab was noticed. The doctor Mrs C spoke to handled this as a concern, and arranged a meeting with relevant staff, with a written summary provided. Mrs C then wrote to the board to complain, and they investigated the issues. The board said the nurses did not consider Mrs A required medical review, and they were capable of making this decision. However, the board acknowledged that their documentation was poor and said they were making improvements to this. Mrs C was dissatisfied with this response, and complained to us about Mrs A's care and the board's handling of her complaint.

After taking independent advice from a specialist renal nurse, we upheld Mrs C's complaint. We found that nursing staff should have taken further action in response to Mrs A's condition, including monitoring the scabbed area and documenting this, and referring Mrs A for access review. However, during our investigation the board gave us information on additional action they had taken to improve their dialysis service after Mrs A's experience and a similar incident, and we considered that the board had now taken appropriate steps to address the failings in care. We also found Mrs C's complaint should have been investigated as a complaint as soon as she had raised it, rather than being handled as a concern.

Recommendations

We recommended that the board:

- feed back our findings to the staff involved for reflection;
- feed back our findings on complaints handling to the doctor involved for reflection; and
- apologise to Mrs A's family for the failures identified.