SPSO decision report

Case: **201507496, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the standard of medical and nursing care and treatment her late mother (Mrs A) received as an in-patient at New Victoria Hospital in October and November 2014. Following a hip operation, Mrs A was transferred from another hospital to a rehabilitation ward at the New Victoria Hospital. She had underlying health conditions (including hospital acquired pneumonia, lung disease and heart disease) and contracted clostridium difficile (a common bacteria that infects the colon). Whilst in hospital, her condition deteriorated and she died less than a fortnight after being transferred to the New Victoria Hospital.

We took independent advice from a medical adviser and a nursing adviser. Turning first to medical issues, we found that while appropriate investigations were carried out within a reasonable time and treatment decisions were reasonable, there were shortcomings. These included that senior clinicians should have been more involved in Mrs A's care and medical staff had failed to implement the relevant do not attempt cardiopulmonary resuscitation (DNACPR) policy. We also found that there was a failure to discuss the possibility of Mrs A's death with her family within a reasonable time. Also, the day before Mrs A's death, medical staff should have discussed her condition with an intensive care unit doctor sooner and it would have been reasonable for medical staff to have had a discussion with them the day before. Related to this, it was not clear whether the on-call doctor had followed up contact from a member of nursing staff about Mrs A's condition or whether they had been informed of her condition following the change of oxygen supply.

Turning now to nursing issues, we found that there were shortcomings in relation to infection control and nutrition which the board had addressed. However, we also found shortcomings around the implementation of an early warning system guidance (the National Early Warning Score - NEWS) and that nursing staff failed to monitor and assess Mrs A on the day before her death in line with this guidance. We also found failings in record-keeping.

Recommendations

We recommended that the board:

- consider the issues around end of life care including communication and take steps to ensure no recurrence;
- bring the medical adviser's comments in relation to record-keeping, implementing the DNACPR policy and escalating difficult significant clinical decisions to relevant staff, and take steps to ensure no recurrence;
- bring the nursing adviser's comments about shortcomings in implementing NEWS policy to relevant staff; and
- apologise for the failures this investigation identified.