SPSO decision report

Case: **201508155, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Mr C's father (Mr A) was admitted to the Queen Elizabeth University Hospital. Mr A died there several days later. Mr C complained to us about Mr A's nursing and medical care and treatment during his admission.

We obtained independent advice from a nurse and a consultant in the care of the elderly. The nursing adviser identified failings in relation to the planning, monitoring and recording of Mr A's nutritional care and hydration and his personal care. They also identified that documentation had not been adequately completed. Mr A appeared to have suffered four falls during his admission. We found it was of concern that Mr A's falls risk appeared to have been ineffectively assessed and there was an unreasonable delay in making a referral to a falls prevention specialist. We also considered that communication with Mr A's family was unreasonable.

While we were unable to conclude that any of these failings were significant contributing factors in Mr A's death, we were satisfied that Mr A's nursing care and treatment fell below a reasonable standard and upheld this aspect of Mr C's complaint.

The medical adviser said Mr A was frail, had a history of heart disease and that there was evidence he had chronic kidney disease. While the advice we received was that a number of aspects of Mr A's medical care and treatment were reasonable, the medical adviser identified issues concerning Mr A's medications. The medical adviser also commented that there was a failure to contact Mr A's family when there was a serious deterioration in his condition. We upheld this aspect of Mr C's complaint.

Recommendations

We recommended that the board:

- issue a full written apology to Mr C and Mr A's family for the failings in Mr A's nursing care and treatment and communication this investigation has identified;
- feed back the comments of the nursing adviser and the findings of this complaint to the nursing staff involved for reflection and learning;
- issue a full written apology to Mr C and Mr A's family for the failings in Mr A's medical care and treatment and communication this investigation has identified; and
- feed back the comments of the medical adviser and the findings of our investigation to the medical staff involved for reflection and learning.