SPSO decision report

Case: **201601706, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained that his care and treatment over two admissions to the Royal Alexandra Hospital was inadequate.

Mr C had suffered from two separate incidences of a collapsed lung in quick succession. During the first admission, Mr C disputed the board's position that it had been reasonable to discharge him. During the second admission Mr C's condition worsened. An x-ray was requested and preparations were made for inserting a chest drain. There was then significant deterioration in Mr C's condition. The board accepted that Mr C could have died due to this deterioration. The board said that they did not believe a critical incident review (CIR) was appropriate in the circumstances. They said that Mr C had been suffering from a complex condition and that it was this, rather than any failings by staff, which had contributed to the deterioration. Mr C disputed this, and he disputed the standard of the nursing care he received. Mr C said his deterioration had not been noticed because he was not being monitored properly.

We took independent medical and nursing advice. The medical adviser said that the decision to discharge Mr C following his first admission was appropriate and was supported by the medical evidence. However, the adviser found that during Mr C's second admission there had been a failure by medical staff to identify that a chest drain had not been correctly inserted, which had contributed to his deterioration. It would therefore have been appropriate to conduct an CIR. The medical adviser noted that Mr C's condition could have deteriorated very quickly and it could not be assumed that the severity of Mr C's condition and deterioration was due to an absence of clinical observation. The nursing advice we received found that, aside from some acknowledged failings, the overall standard of care was reasonable. The board had accepted the nursing failings and had taken action to address them.

We found that the board should have conducted a CIR into Mr C's deterioration during his second admission, as this could have identified useful learning for staff. We also found that the board should provide evidence that it had followed through with the work it had committed to in order to address the nursing failings it had accepted had taken place. On balance, we upheld Mr C's complaint that the care and treatment provided to him across the two admissions had been inadequate.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failings in his care, and for failing to carry out a critical incident review. This apology should comply with SPSO guidelines on making an apology.

What we said should change to put things right in future:

- The board should review Mr C's second admission and his subsequent deterioration with the clinical staff

involved. This review should include what action was taken to review the x-ray taken and the action taken on Mr C's subsequent deterioration. This review should also include evidence of the resultant learning or improvements.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.