SPSO decision report

Case: **201800220, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Ms B) about the care and treatment provided to Ms B's daughter (Ms A) at Glasgow Royal Infirmary. Ms A was admitted to the hospital on two occasions due to complications from her gastric band (a band placed around the stomach to give a feeling of fullness with less food). Ms A died at home, a month after she was discharged from hospital on the second occasion.

When Ms A was discharged the first time, she waited all day for an ambulance to come to transport her home. Ms C complained that nursing staff did not allow Ms A back to bed while she waited, even though she was very uncomfortable. We took independent advice from a nurse. We found that there was no record of Ms A's nursing care needs being assessed or met while she waited for the ambulance. We upheld this aspect of the complaint.

Ms C explained that during her second admission, Ms A began to experience difficulties with her hands. Ms C complained that Ms A was not given appropriate help with eating. We found that there was a failure to assess, plan and review Ms A's nutritional care needs, with Ms A's involvement as appropriate. We upheld this aspect of the complaint.

Ms C also complained that Ms A was unreasonably discharged home without appropriate communication, particularly with her GP, about her malnutrition. We took independent advice from a consultant surgeon. We found that it was reasonable Ms A was discharged home. However, we also found that the concerns about Ms A's nutritional status and difficulties with eating should have been communicated to her GP in her discharge letter. In light of this, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms B for the failings identified in appropriately assessing, planning, reviewing and recording Ms A's nutritional care needs, and for failing to include all relevant clinical information in Ms A's discharge letter. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- The needs of patients who are waiting to be discharged from hospital should be appropriately met while they remain on the ward.
- There should be patient-centred nutritional care assessment, planning and review.
- Clinical issues of concern should be included in discharge letters so GPs are aware of the need to keep them under review.