SPSO decision report

Case: **201803281, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: nurses / nursing care
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her by the board at Queen Elizabeth University Hospital when she was admitted with cellulitis (a bacterial skin infection) and with sepsis (blood infection). She complained about nursing and medical care in A&E and the acute receiving unit (ARU).

We took independent medical advice from a senior nurse, a consultant in emergency medicine, and a consultant in acute medicine. In relation to nursing and medical care in the A&E, we found that this was reasonable and we did not uphold these aspects of Ms C's complaint. However, we identified failings in the monitoring of Ms C's condition by nursing staff in the ARU. We upheld this aspect of Ms C's complaint, however, we noted that the board had previously acknowledged this and had taken action to address these failings.

In relation to medical treatment in the ARU, we found that the fluids prescribed to Ms C were unreasonable as they were not a recommended fluid for patients with sepsis, and they were not provided at a fast enough rate. We also noted that there was a failure to recheck Ms C's national early warning score (NEWS - an aggregate of weighted physiological parameters that gives an indication of how unwell a patient is, or if they are deteriorating) prior to transferring her to another ward. We therefore upheld this aspect of Ms C's complaint.

Ms C also complained about the board's handling of her complaint. We found that the board did not respond to the complaint within the required timescale and for this reason we upheld this aspect of Ms C's complaint. However, as the board had apologised and learnt from this matter already, we did not make any further recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the failure to prescribe intravenous fluids reasonably based on the relevant guidance; and the failure to recheck her NEWS score prior to transferring her to another ward. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets

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

- Intravenous fluids should be prescribed in line with relevant guidance.
- NEWS scores should be rechecked appropriately prior to transfer.

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.