

SPSO decision report



Case: 201809934, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: clinical treatment / diagnosis

Decision: some upheld, no recommendations

Summary

Mrs C complained that the care and treatment provided to her late mother (Mrs A) at Royal Alexandra Hospital was unreasonable. Mrs C also complained that the board's communication with Mrs A's family was unreasonable.

Mrs C said that staff had acted unprofessionally when asked for help changing Mrs A's position. Mrs C also told us she had frequently observed nursing staff inaccurately recording information on Mrs A's care plan, food and fluid charts. During our investigation we found that Mrs C had made amendments on the nursing records where she perceived them to be wrong. It was unclear though where Mrs C had made amendments so we were unable to assess the quality of the records. It also meant we were unable to clearly identify failings in the board's care and treatment of Mrs A. We therefore discontinued our investigation of this aspect of the complaint.

Mrs C told us the board's communication with Mrs A's family was unreasonable because staff did not provide them with updates about Mrs A's condition. She also said that on a couple of occasions staff told Mrs A that she would be going home and a care package would be organised, only for her later to be told the care package had been cancelled due to lack of carers. We found that although the medical records demonstrated that staff spoke to Mrs A's family about her condition throughout her stay in hospital, it was clear that Mrs A's family did not feel they knew enough about what was happening and, in particular, when Mrs A could be discharged. In response to Mrs C's complaint to them, the board apologised for their communication with Mrs A's family and the distress caused by the uncertainty about Mrs A's discharge date. They agreed this should have been communicated more effectively. We upheld this aspect of the complaint but made no recommendations as the board had already taken appropriate action.