SPSO decision report

Case: **201904243, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their family member (A) received from the board.

A had a complex medical history and received treatment in hospital on a number of occasions. C became aware that a wound that A had on their leg had deteriorated. C was very concerned about the condition of the wound.

C complained that, although A had been in and out of hospital on a number of occasions, the board had failed to take reasonable steps to treat A's leg wound. They complained that A was discharged from hospital on multiple occasions following treatment for infections, but that follow-up arrangements were inadequate and, as a result, the leg wound was left to deteriorate. C said that A had suffered both physically and mentally and that family members had been extremely distressed seeing A suffer.

We found that A's complex medical history meant that they had multiple hospital admissions and that they were seen regularly by community based district nurses and tissue viability nurses. A's wounds were quite severe and were complicated by the fact that their condition caused their leg muscles to contract, keeping the two skin surfaces together and difficult to access for pressure-relieving treatment. There was no suggestion that the wound on A's leg was caused, or made worse, by any shortfall in the care and treatment provided by the board.

We were satisfied that staff caring for A were aware of their wounds and made efforts to relieve the discomfort that they caused as well as working towards helping them to heal. Upon each admission to hospital, A's wounds were assessed and a referral was made to the tissue viability service for review. Whilst on some occasions A was discharged home before the review could occur, they continued to receive care at home from the community tissue viability nurses.

Whilst overall we were satisfied that A's wounds were taken seriously and a management plan was in place, we found that some discharge documentation was incomplete and that communication between the hospital and community based teams was lacking at times. As such, the most up-to-date review information from the acute tissue viability service may not have been communicated to the community nurses who provided the regular care that A required. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet thestandards set out in the SPSO guidelines on apology available atwww.spso.org.uk/information-leaflets.

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

- Consider holding a multi-disciplinary team meeting to discuss how to improve communication between

teams and provide a holistic approach to care for individuals with multiple needs.
- Remind all appropriate staff of the importance of completing all discharge documentation and wound care charts.

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.