SPSO decision report

Case: **202004184, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about various aspects of the treatment provided by the board to their late parent (A) who was initially admitted to Glasgow Royal Infirmary with a fractured hip following a fall. A was subsequently discharged after surgery and received care at home from district nurses. However, A developed an infection at the site of their surgical wound and was readmitted to hospital, where they underwent several further surgeries to control the infection. A went on to develop further infections and subsequently died.

C complained that there had been a delay in carrying out surgical repair of the hip, that A had been discharged without appropriate physiotherapy follow-up, that an out-of-hours GP had failed to readmit A to hospital sooner and that nursing staff were unaware of a surgical procedure A had undergone. C also complained that there had been a delay in referring A to psychiatry, that A developed further infections, that A's skin had not been correctly looked after, that there had been poor communication about the decision to withdraw care and that there had been errors on A's death certificate.

We took independent advice from specialists in orthopaedic surgery, general practice community nursing and hospital nursing. We found that reasonable care had been given in relation to the choice of surgical procedures A underwent. We also found that reasonable care had been given to the management of A's infections whilst in hospital, the level of community nursing care, the management of A's skin, PICC line (a thin flexible tube inserted through a vein to give medicine directly into the bloodstream), referral to psychiatry and end of life care. However, we found that there had been unreasonable care provided in relation to a delay in carrying out A's initial surgery. We also found failures by an out-of-hours GP to record sufficient detail about A's condition and ensure A was provided with prompt antibiotic treatment, requiring A to complete two consent forms for the same surgical procedure. We further found that there was a failure to discuss with A's family a decision taken by clinicians not to perform cardio-pulmonary resuscitation (where the heart and/or breathing is re-started if it stops) of A were it to be required. We also found instances of poor record-keeping by nursing staff and errors contained within A's death certificate. As such, 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 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:

- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions should be discussed with the patient or their power of attorney/next of kin and the DNACPR form should be completed appropriately.
- Patients' death certification should be completed accurately.
- Patients' nursing care should be clearly and accurately recorded. Entries should be legible, signed and

dated and the use of abbreviations should be minimised.

- Patients should be given appropriately and timely treatment by out-of-hours GPs, which is clearly recorded.
- Patients should be given clear information during the surgical consent process to ensure that they are fully informed.
- Patients with a suspected hip fracture should be appropriately investigated within a reasonable timeframe.
- The nursing staff caring for a patient should have appropriate knowledge of their medical history including their care and treatment.

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.