SPSO decision report

Case: **201507971, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C's mother (Mrs A), who was diabetic, injured her toe. Mrs A attended A&E at the Royal Alexandra Hospital a few days later. Mrs A's toe was found to be broken and there was evidence of infection. At that time, Mrs A was keen to avoid admission and she was sent home with antibiotics. After initial improvements in her condition, Mrs A had to re-attend at A&E and was admitted for around two weeks. During this admission, Mrs A became unwell and had to be resuscitated. On her discharge, Mrs A's injured toe was noted to be necrotic (where the cells or tissue are dead). Mrs A was readmitted to the hospital later that month after being seen at the diabetic foot clinic.

Ms C complained about the A&E care provided to Mrs A, the medical care and treatment provided to Mrs A while she was an in-patient, the nursing care, the standard of communication and the approach in the Coronary Care Unit (CCU) to visiting.

After taking independent advice from a consultant in emergency care, we upheld Ms C's complaint about the initial A&E attendance. We found that due to Mrs A's diabetes, a referral should have been made to a specialist foot team. Although the advice we received was that this did not affect the outcome for Mrs A, we considered this to be a failing. The board identified this during their own investigation and we considered that they had taken reasonable steps to address the issue.

In relation to Ms C's concerns about the standard of in-patient medical care and treatment, we took independent medical advice. The adviser found that Mrs A received optimal care and treatment. We therefore did not uphold this part of Ms C's complaint.

After taking independent nursing advice, we upheld Ms C's complaint about nursing. The advice we received was that there were failings in obtaining an appropriate mattress for Mrs A and that there had been some issues around wound dressings. The board had already apologised for this and for an occasion where fluids were administered more quickly than intended. The nursing adviser also noted that a fluid balance chart had not been properly completed. We made a recommendation to address this.

We found that the approach of some of the staff regarding Mrs A's family visiting her in the CCU was not reasonable. The board had identified failings in communication with Mrs A's family and apologised for these. We therefore upheld this aspect of Ms C's complaint.

Recommendations

We recommended that the board:

- ensure that fluid balance charts are appropriately completed for patients;
- make all relevant staff in the CCU aware of the nursing adviser's comments on visiting; and
- review the approach to visiting in the CCU in light of the nursing adviser's comments.