# SPSO decision report

**Case:** **201508133, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** appliances / equipment / premises
**Outcome:** upheld, recommendations


## Summary

Mrs C complained to us about the care and treatment her son (Mr A) received at Queen Elizabeth University Hospital before his death.

Mrs C said that the hospital had not been equipped to meet Mr A's needs. We took independent advice from a nursing adviser. We found that there had been a delay in obtaining an appropriate specialist bed for Mr A. There were also problems in relation to Mr A's bed sheets and in obtaining an appropriate hoist for him. We upheld this complaint. However, the board had apologised to Mrs C for these failings and we were satisfied that they had taken reasonable steps to try to prevent these problems from recurring.

Mrs C also complained about the nursing care provided to Mr A. We found that there had been problems with the meals provided to Mr A and with the buzzer being out of his reach. Again, we upheld Mrs C's complaint but we were satisfied that the board had apologised to Mrs C for these failings and had taken steps to prevent them recurring.

Mrs C complained that there had been no explanation as to why Mr A had not been offered dialysis. She said that dialysis had been mentioned to Mr A over several days as a possible procedure, but that this was then postponed. We took independent medical advice on this aspect of Mrs C's complaint. We found that the decision that Mr A did not require dialysis had been reasonable, but that the communication of this to him and his family had been inadequate. Mrs C complained that there had not been a reasonable standard of communication with family members. In regard to this, the adviser was critical of the record-keeping. We upheld these aspects of Mrs C's complaints.

Finally, Mrs C complained that reasonable arrangements were not in place for the storage and security of personal belongings. We upheld this complaint, as we found that there had been some confusion about where Mr A's belongings were being stored in the hospital. In addition, there was no evidence that Mrs C had been informed of the outcome of an investigation into Mr A's missing watch.


## Recommendations

We recommended that the board:

- provide us with evidence that steps have been taken to ensure that medical records are maintained appropriately;
- issue a written apology to Mrs C for the failure to communicate adequately with Mr A and his family;
- ensure that there are adequate systems in place in the hospital for the safe storage of patients' belongings; and
- ensure that Mrs C is informed of the outcome of the investigation into Mr A's missing watch.