SPSO decision report

Case: **201606220, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, an advocacy worker, complained on behalf of her client (Mr B) about the care and treatment provided to his late father (Mr A) at Queen Elizabeth University Hospital. Mr A had dementia and was admitted to hospital by ambulance after becoming unwell at home. It was suspected that he had urinary retention (inanbility to empty the bladder) and a urinary tract infection. Mr A was treated with antibiotics and fitted with a catheter (a thin tube used to drain and collect urine form the bladder). While in the hospital, Mr A suffered a fall and also developed pressure ulcers. After surgery to fix a bone broken during a fall, Mr A's condition worsened and he developed pneumonia (an infection of the lungs). Mr A's condition continued to deteriorate and he later died. Ms C made several complaints about the treatment that was provided for Mr A's urinary tract infection, catheter care, prevention of falls and pressure ulcer care.

We took independent advice from a consultant in acute medicine, a consultant urologist and a nursing adviser. In relation to urinary tract infection treatment and catheter care, we found that Mr A had been started on antibiotics which was reasonable. However, a scan of his urinary tract and bladder had not been carried out ahead of catheterisation. We also found that the completion of catheterisation records was inadequate and that it had been difficult for staff to contact the on call urology team at some points. We noted that Mr A pulled on his catheter and that there had been difficulties in re-catheterising.

In relation to fall risk management and pressure ulcer care, we found that the care planning in the assessment of these risks was unreasonable. We upheld all of Ms C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr B for the failings identified in the investigation of Mr A's urinary tract infection; his catheterisation; and in the assessment and management of his falls and pressure ulcer risk. The apology should comply with the SPSO guidelines on making an apology, available at www.spso.org/leaflets-and-guidance.

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

- Bladder scans should be considered and carried out where appropriate.
- Staff should be able, as far as possible, to obtain specialist urology advice/assistance when necessary.
- Accurate medical records should be maintained.
- Staff should respond appropriately in cases where patients try to pull out catheters and have the appropriate catheterisation skills.
- There should be sufficient support and guidance for nurses to carry out comprehensive, structured assessment and care planning. The patient should be re-assessed and their care plan updated as needed throughout the hospital stay. There should be evidence that the patient or their power of attorney informs

the care plan and participates in its review.

- National guidance on the prevention and management of pressure ulcers and standards of care for older people in hospital should be implemented appropriately.
- Appropriate pressure relieving equipment should be identified and obtained timeously. There should be an escalation process where there are delays in equipment being available.

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.