SPSO decision report

Case: **201607956, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Miss C complained about the care and treatment her late mother (Mrs A) received while she was a patient at Inverclyde Royal Hospital. Mrs A was taken to hospital after she was unable to return to bed, finding her legs were too weak. She spent time in the emergency department before being transferred to two different wards. Mrs A died shortly after. Miss C complained about the standard of both clinical and nursing treatment Mrs A received, that the board failed to communicate adequately with her and that they did not respond to her complaint reasonably.

We took independent advice from a consultant physician and a nurse. In relation to Mrs A's clinical and nursing care, we found that certain aspects of her care in the emergency department had been reasonable. However, we also indentified a number of failings including a failure to recognise and investigate whether Mrs A, given her presenting symptoms, may have had a stroke or sepsis (a blood infection). We also noted there was a delay in administering intravenous fluids and rechecking her National Early Warning Score (NEWS - an aggregate of a patient's 'vital signs' such as temperature, oxygen level, blood pressure, respiratory rate and heart rate which helps alert clinicians to acute illness and deterioration).

While in the first ward, we found that staff had difficulties interpretating an x-ray of Mrs A's and that there was no written plan as to what to do about clarifying this. We also noted that the board failed to consider whether Mrs A had suffered a subdural haematoma (where blood collects between the skull and the surface of the brain) or possible sepsis. We also noted a failure to ensure that she had received appropriate fluids, monitor her urine output, issues with record-keeping, and a failure to anticipate, recognise and address that she was deteriorating and to plan for this in line with national recommendations. There were also multiple attempts to catheterise Mrs A and no account appeared to have been taken of the distress and discomfort this may have caused her.

When Mrs A was transferred to another ward, we found that there was a failure of continuity of handover between the medical teams caring for Mrs A. It also appeared that although Mrs A was having active treatment with intravenous fluids and regular NEWS, at the same there was a failure to act on her elevated NEWS, recognise that she was dying and manage her end of life care appropriately. Overall, we found that both the clinical and nursing care provided to Mrs A was unreasonable and we upheld these aspects of Miss C's complaint.

In relation to communication, Miss C said that staff failed to inform her or consult with her about Mrs A's care and treatment during her admission, despite the fact that she held welfare power of attorney. We found that an Adults With Incapacity form had not been completed and that Miss C had not been consulted about the plan to insert a catheter. We considered that there appeared to have been a lack of evidence of Miss C having being proactively and regularly updated and a failure to try to understand her needs, expectations and concerns about Mrs A. We also noted that that Mrs A's deterioration did not appear to have been communicated effectively with Miss C. Therefore, we upheld this aspect of her complaint.

In relation to how her complaint was handled, Miss C said that she had not been informed that a significant clinical

investigation (SCI) was carried out by the board until she received a copy of the report by the Procurator Fiscal (a legal officer who performs the duties of public prosecutor and coroner). We considered that the board had kept Miss C appropriately updated on the investigation into her complaint, however, the delay was unreasonable. We also noted that she was unaware that the SCI was being carried out and we considered that the board should not have left it to the Procurator Fiscal's office to have made her aware of the SCI report. Therefore, we upheld this aspect of Miss C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for failing to provide Mrs A with reasonable medical and nursing care and for the failure to reasonably communicate with her about Mrs A's care and treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Where patients present with fluctuating conscious level and reduced power in their limb(s), consideration should be given to whether they have had a stroke or a subdural haematoma and to carrying out a CT brain scan. When patients transfer from the emergency department to an acute medical ward there should be an appropriate re-examination of the patient including their case history.
- Where patients who present meet the SIRS (systematic inflammatory response syndrome), criteria consideration should be given to whether they may have sepsis and appropriate investigations carried out.
- Where patients present with deterioration and fluid overload, consideration should be given to performing a renal ultrasound to look for any obstruction in the urinary tract.
- Where there are difficulties by staff in interpreting an x-ray, consideration should be given to obtaining a formal report from the radiologist or asking for it to be reviewed by a more senior member of staff.
- There should be in place a structured response to patient deterioration where it is clear that the patient is failing to improve or continues to deteriorate as recommended by national guidance.
- Consideration should be given to seeking a more expert practitioner to assist with catheterisation after repeated attempts.
- Where a patient's prescribed rate of fluid is changed, this should be entered on their fluid prescription sheet.
- An Adults with Incapacity form should be completed for patients who lack capacity and discussed with the person who has power of attorney wherever possible.

In relation to complaints handling, we recommended:

- Wherever possible, complaints should be investigated and responded to in line with the board's complaints handling procedure. Where a SCI review is to be carried out, staff should ensure that the patient and/or their family is clearly informed of the action that is being taken.

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.