SPSO decision report

Case: **201303888, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained on behalf of her daughter (Ms A) about the care and treatment she received at the Western Infirmary for appendicitis. She complained that her daughter was not fully diagnosed soon enough, as there was a delay to her initial scan, and she was not monitored appropriately. She also said that a delay in operating to remove Ms A's appendix caused a rapid deterioration in her condition and a more complex operation. Ms A was operated on some 24 hours after she was admitted to hospital. Ms C also complained about the board's handling of her complaint.

The board had accepted that there was poor communication in relation to some elements of Ms A's care, and that the family were misled in relation to when the operation might take place. They apologised for the distress this caused.

After taking independent advice from two of our advisers - a consultant surgeon and a nursing adviser - we upheld both complaints. The surgical adviser was satisfied that Ms A's treatment was reasonable, and that the operation took place within a reasonable timeframe. However, the nursing adviser was concerned that Ms A was not monitored frequently enough, given that the reason for admitting her to hospital was to keep her under close observation. We were also critical of the communication between ward staff and Ms C. She was given inaccurate information on at least three occasions, increasing the family's distress.

We found that the board had delayed in responding to Ms C's complaint, and did not act on assurances they had given during that process. The board explained to us, however, what they had since done to ensure that this did not happen again, so we made no recommendation about this aspect of Ms C's complaint.

Recommendations

We recommended that the board:

- reflect on the failures in communication that our investigation identified, and consider how communication with patients and their families could be improved to ensure information is as accurate as possible; and
- ensure that nursing staff within the surgical unit are aware of the importance of carrying out vital signs observations as part of their role in the assessment and monitoring of surgical patients.