SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201605522, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A). Mr A was admitted to hospital as an emergency with abdominal pain, and investigations were carried out over the next few days. Following a request by the family for medical review, Mr A was reviewed by a surgeon and a scan was carried out, which showed a bowel obstruction. Mr A had surgery the next day. Following this, Mr A was transferred to the high dependency unit (HDU) where he contracted a chest infection. He was then transferred to a ward, but his condition deteriorated and he developed sepsis. Mr A was transferred back to the HDU four days later, and then into intensive care. His condition deteriorated further, palliative care (end of life care) was started and Mr A later died.

Mrs C complained to the board about the care and treatment provided to Mr A. The board met with Mrs C about her complaints and carried out a significant clinical incident review. Mrs C was not satisfied with the outcome, or the way the board handled her complaint, and so she brought her complaints to us. She complained that the board did not provide reasonable medical treatment to Mr A, did not provide reasonable nursing care to Mr A, did not communicate reasonably with the family during Mr A's admission, and did not respond reasonably to her complaints.

We took independent advice from a consultant in general medicine, a nurse and a consultant radiologist (a doctor who uses medical imaging such as x-rays, ultrasounds and scans to diagnose and sometimes treat ilnesses). We found that there were delays in investigating and diagnosing Mr A's condition, and in identifying, responding to, and recording the deterioration following the surgery. We also found that there was no documentation of the reasons for transferring Mr C from the HDU, and poor documentation of a decision to commence using a ventilator. We found that, while aspects of the communication with the family were reasonable, on the whole the standard of communication fell below a reasonable standard, especially in light of the fact that the family held power of attorney. We upheld Mrs C's complaints about medical care and treatment, and about communication.

We did not find failings in the nursing care provided to Mr A, and so we did not uphold this aspect of the complaint.

We found that the board had failed to respond to many of the issues Mrs C had raised in her complaints, despite taking a significant amount of time to investigate. The board was also poorly prepared for the meeting they had with Mrs C about her complaints. We upheld Mrs C's complaint about the board's handling of her complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in medical care and communication, and for failing to respond to the points raised in her complaint.The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Patients should be reviewed regularly, with prompt consideration of the results of any investigations to inform diagnosis and treatment.
- Medical staff should clearly record the reasons for key decisions.
- Deterioration in patients should be identified and escalated to senior staff, with timely transfer to high-dependency care where appropriate.
- Welfare attorneys should be involved in decisions about care, and discussions should be clearly documented.

In relation to complaints handling, we recommended:

- The board should adequately prepare for complaint meetings by ensuring staff attending are aware of the specific complaint issues and are able to respond to the specific issues and discuss the timeframes covered by the complaint. They should also agree an agenda or format prior to the meeting, to ensure shared expectations.

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.