SPSO decision report



Case: 201703147, Greater Glasgow and Clyde NHS Board - Acute Services Division Clyde NHS Board - Acute Division Clyde NHS Board - Acute Division Clyde NHS Board - Acute Division Clyde NHS Board - Ac

Sector: health

Subject: clinical treatment / diagnosis

Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment she received from the board following spinal surgery. We took independent advice from a consultant neurosurgeon (a doctor who specialises in conditions of the nervous system, including the brain, the spine, the spinal cord and nerves) and from a nurse.

Firstly, Mrs C complained that the board failed to reasonably prevent and treat her infection following the surgery. We found no evidence that the board had failed to prevent the infection. However, we found that Mrs C was not assessed and treated as soon as the results showing the infection were reported. There had also been a delay in carrying out a wound washout which was unreasonable. We, therefore, upheld this complaint.

Mrs C also complained that the board failed to provide her with appropriate pain relief immediately after surgery. We noted that the board had acknowledged their failing in relation to providing post-operative pain relief and had apologised for this. We upheld this aspect of Mrs C's complaint.

Mrs C also complained that the board failed to provide a reasonable standard of nursing care following her operation. We found that overall the nursing care was reasonable and did not uphold this aspect of Mrs C's complaint.

Finally, Mrs C complained that the board unreasonably delayed in responding to her complaint. We found inaccuracies in the board's response, and that there were delays in acknowledging and responding to the complaint. Further to that, the board did not keep Mrs C updated about the delay. We also noted that the board did not appear to have kept a full record of their internal investigation. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

Apologise to Mrs C for the delays in treating her wound infection and the inaccuracy in their complaint
response. 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:

- Lab results showing infection following spinal surgery should result in prompt assessment and treatment.
- Emergency wound washouts should be carried out promptly.

In relation to complaints handling, we recommended:

• Complaint responses should be accurate and supported by relevant evidence in the medical records. Any failings should be openly acknowledged and used to improve services and prevent a recurrence of the

issues found.

- Stage 2 complaints should be acknowledged within three working days and responded to within 20 working days where possible.
- Where complaints cannot be responded to within 20 working days, the board should give a revised timeframe and keep the complainant updated regularly (for example, every four weeks).
- Complaint files should include records of all the information gathered during an investigation (and copies of internal correspondence about this).