SPSO decision report

Case: **201809468, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, an advocacy worker, complained on behalf of (B) about the care and treatment provided to B's family member (A) before their death. Around three months prior to A's death, they attended their GP with back pain, nausea and feeling generally unwell. They subsequently attended Accident and Emergency (A&E) at Inverclyde Royal Hospital on two occasions, before being admitted to the Royal Alexandra Hospital via A&E there. A was diagnosed with a rare and aggressive type of cancer and died a short while later. C complained on behalf of the family that A was not investigated more thoroughly given their symptoms and medical history, and that the family was not included in discussions about A's care.

We took independent advice from a consultant in emergency medicine. With regards to care and treatment, we found that appropriate investigations were carried out during A's hospital attendances and reasonable management plans were put in place. While we considered that there could have been closer attention to pain measurement recording, and a referral to an out-patient clinic could have been made by A&E staff directly (rather than relying on A to re-attend their GP for this purpose), we accepted that improvements in these aspects of care would not have altered the outcome for A. On balance, we did not uphold this aspect of C's complaint.

Regarding communication with A's family, we noted that A was a competent adult and it is not expected practice to involve family members in treatment decisions when the patient has capacity. The records indicated that medical staff did speak with A's family on occasion and we were satisfied that they were not deliberately excluded from discussions. As we found no significant omissions in communication, we did not uphold this aspect of C's complaint.

C also complained about the board's handling of the complaint. We found that the complaint was not responded to in a timely and robust manner. An initial meeting was held with A's family but the board did not follow this up in writing. Additional questions and concerns developed during A's family's wait for a written response. Delays were not proactively explained and revised timescales were not communicated to C. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the identified failures in the handling of their complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

- The board should ensure complaint investigations conform to the NHS Model Complaints Handling Procedure, particularly in terms of the requirement to respond in writing and in a timely manner. They

should review their handling of this complaint with a view to identifying areas for learning and improvement.

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.