SPSO decision report

Case: **201811033, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (B), regarding the care and treatment provided to B's late partner (A) when A was admitted to the Royal Alexandra Hospital with back pain. C complained that:

A was inappropriately prescribed Pabrinex (a vitamin infusion injection often given to patients with alcohol dependency);

the Abbreviated Mental Test 4 (AMT-4, a rapid test to detect cognitive impairment) and 4AT test (a slightly longer screening test for cognitive impairment and delirium) were not carried out appropriately;

there was a delay in carrying out an MRI; and

A was treated differently due to the incorrect assumption that they were experiencing symptoms due to alcohol access.

We took independent advice from a consultant in orthopaedics (a specialist in the treatment of diseases and injuries of the musculoskeletal system). We found that:

the prescription of Pabrinex was unreasonable;

it was unreasonable that the AMT gave a score of zero, which would indicate severe cognitive impairment, but there was no documented action taken as a result of this outcome;

there was no indication that an MRI scan needed to be carried out earlier than it was; and

there was no indication that A was treated differently because of an incorrect assumption that they were suffering from alcohol excess.

We also found that in relation to the AMT score, the board gave inaccurate information to C and B in the complaint responses as they stated that a score of zero indicates no cognitive impairment. We upheld C's complaint about care and treatment.

C also complained that the minutes of the complaint meeting and follow-up actions were unreasonable. We considered that it was clear from the minutes of the meeting that there were several things that the board had committed to during the meeting that then do not appear to have been taken forward. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the unreasonable prescription of Pabrinex, the failure to take appropriate action on the AMT score of zero; the inaccurate information in the complaint responses, and failing to take forward actions agreed during the complaint meeting or provide an explanation as to why this was not possible. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- If the AMT gives a score of zero, which would indicate severe cognitive impairment, appropriate action should be taken as a result of this.
- Pabrinex should only be prescribed where clinically appropriate and the reasons for the prescription should be documented.

In relation to complaints handling, we recommended:

- Complaint responses should be accurate.
- During and after complaint meetings, care should be taken to ensure that all agreed actions are documented and either taken forward, or if it is not possible to take forward actions, an explanation is given to the complainant as to why this is.

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.