SPSO decision report

Case: **201911488, Angus Health and Social Care Partnership**
Sector: Health and Social Care
Subject: Continuing care
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) by their GP practice whilst they were resident in a care home. A suffers from dementia and fell in the care home. A was reviewed and treated by several GPs in relation to their pain and urinary infection. C's complaint is concerning the care and treatment of A, the standard of communication from both the GPs and the partnership, and the partnership's handling of the complaint.

C said that A had been left for almost two weeks with two broken vertebrae following their fall. C complained that A's pain was not appropriately managed as they had become 'toxic' from the high levels of morphine in the Butec patches (pain-relief patches) provided and that they continued to suffer urinary infections. C complained that they did not have adequate communication from the GPs about A's condition and that the record of the discussions that did take place were not accurately documented in the medical notes. C also complained about the communication from the partnership during the investigation of their complaint. C raised concerns about the handling of the complaint, stating it was chaotic and confused and that the partnership did not respond to their further points of concern.

We took independent advice from a GP adviser. We found that A's pain and urinary infections were appropriately managed and as such, we found that the care and treatment provided was reasonable. We did not uphold this complaint.

With regards to communication from the GPs with C, whilst we noted that there were differing accounts of the same interactions, we found that, overall, communication from the GPs was of a reasonable standard. However, we found that communication from the partnership when C first raised their complaint fell below the expected standard. As such, we upheld this complaint. In addition to this, we upheld C's complaint about the partnership's handling of the complaint as we found multiple complaint handling failures, including a failure to address all of C's concerns and to indicate whether complaints were upheld or not.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to communicate with them reasonably about their complaint and the partnership's investigation into it. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for failing to handle their complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- The partnership should include with their apologies the learning points from the Significant Event Analysis.

In relation to complaints handling, we recommended:

- Staff dealing with complaints should be familiar with the Model Complaints Handling Procedure, understanding the importance of communication and the need to demonstrate thorough investigation of the points raised.
- Staff dealing with complaints should be familiar with the Model Complaints Handling Procedure, understanding the importance of recording consistently whether complaints have been upheld or not, and communicating this to the complainant.

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.