SPSO decision report

Case: **202205577, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the board failed to provide their late partner (A) with reasonable treatment for bladder incontinence. A was admitted to hospital following a fall in which they fractured their hip. A was catheterised after undergoing surgery. C complained that when A's catheter was removed, they developed a bladder problem, and that hospital staff did nothing to rectify A's inability to control their bladder or investigate what was causing this. C believed if A's bladder problem had been addressed they may have made a full recovery. A's condition deteriorated after discharge and they died within a few weeks.

When the board originally responded to C's complaint they said that it was documented in the nursing notes that A was incontinent on three occasions. The board said a urine specimen was taken which returned a positive result for a urinary tract infection and A was treated with oral antibiotic medication. The board said that prior to discharge, A was mobilising to the toilet and there was no mention of incontinence thereafter.

C highlighted a number of entries in A's records which referred to incontinence/use of pads. We asked the board to comment on this, noting this contradicted their position in the complaint response. The board confirmed that if all this information had been considered by the multi-disciplinary team, this may have prompted additional continence support and follow-up being arranged on A's discharge from hospital. The board confirmed that they were taking forward learning points including an action plan for improvement.

We took independent nursing advice. We found that despite a number of references within the multidisciplinary notes to A's incontinence, there appeared to have been no attempts to explore this further and to provide appropriate support during A's admission and/or follow-up after discharge from hospital. Although the board missed an opportunity to address these issues, it was not possible to determine the extent of the impact on A, who had a number of significant health concerns. We upheld C's complaint and made a recommendation for apology. We considered that the action plan appropriately addressed failings so made no further recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide reasonable treatment for A's incontinence and for failing to appropriately identify concerns about A's bladder issues in their investigation of C's complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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.