

## SPSO decision report



**Case:** 202209336, Greater Glasgow and Clyde NHS Board - Acute Services Division  
**Sector:** Health  
**Subject:** Admission / discharge / transfer procedures  
**Decision:** some upheld, recommendations

### Summary

C complained about the care and treatment provided to their adult child (A). A had addiction issues and was admitted to intensive care with a head injury after a fall. They were later transferred to a different hospital and onto a ward after their condition improved. A received treatment from the addiction team while in hospital and following further scans and reviews, was deemed fit for discharge. A died at home shortly after discharge.

C complained that the board failed to provide A with a reasonable standard of medical or nursing care. They also said that the board failed to communicate appropriately with social services or community addiction services prior to A's discharge.

We took independent advice from a consultant neurosurgeon (specialist in surgery of the nervous system, especially the brain and spinal cord) and a nurse. We found that both the medical and nursing care A received was appropriate. Therefore, we did not uphold this aspect of C's complaint. However, we found that A's discharge did not adequately consider their vulnerability and whether A would be safe in the community. We considered that the board did not communicate appropriately with social services and addiction services. Therefore, we upheld this part of C's complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in the report. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/information-leaflet](http://www.spsso.org.uk/information-leaflet).

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

- When discharging vulnerable individuals, particularly when they live alone, the board should ensure that the level of support being provided in the community is recorded. Where appropriate, this should be discussed with the patient and /or their family as well as social services.

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.