SPSO decision report

Case: **202304148, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A). A was admitted to hospital and received treatment for a chest infection and pleural effusion (a build-up of fluid in the chest). A remained in the hospital awaiting discharge arrangements. During a visit to A, C was told that A's bed was needed for a more acute patient and that A would be transferred to a maternity ward as a boarder. C complained that A was not included in this conversation, and that the family felt pressured to accept an unsuitable move. They were concerned that it would negatively impact A's care and wellbeing due to noise, disruption and the availability of equipment.

The board stated that A had been identified as a patient suitable for boarding and that ward moves are necessary when there is extreme pressure on capacity. The board also considered that the care provided to A was not affected by the move.

We took independent advice from a consultant specialising in acute medicine. We found that A was not considered suitable for boarding under the board's policy. We also found that there had been a failure to conduct and record a full risk assessment, and to record the reasons for this deviation from policy. There was evidence that the move caused A distress leading to a deterioration in their behaviour and acceptance of treatment. Therefore, we upheld this part of C's complaint.

C also complained that the board's complaint response focussed on allegations of aggressive behaviour from A's family towards hospital staff. C did not consider that this accurately represented events.

We found evidence of challenging behaviour documented in the available records. However, the board's complaint response unreasonably focussed on these events, which were not ongoing. Therefore, we considered that the board failed to handle C's complaint reasonably and upheld this part of their complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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

- All decisions regarding boarding patients should be made following appropriate clinical considerations and a formal risk assessment. These should be clearly documented. Should a situation arise when a decision is made to deviate from the board's policy due to exceptional pressures, a clear rationale should be documented outlining why the decision has been made and how the risks have been weighed.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the NHS Complaints Handling Procedure.

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.