SPSO decision report

Case: **201201858, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C's mother (Mrs A), who suffered from Parkinson's disease, was admitted to hospital where she stayed for almost three months. After three weeks, she was transferred to a long-term ward before being discharged to a care home. Mr C said he was told that Mrs A was being transferred due to pressure on beds and would now be under the care of another consultant. He believed, however, that the consultant did not see Mrs A at all during her five week stay in that ward. He also believed that staff failed to ensure that Mrs A took her medication. Mr C also noted there was no walking frame in the ward and was told there was no rehabilitation or occupational therapy there. He had noticed that Mrs A's left hand had become rigid, and believed this was down to a lack of mobility opportunities and failure to provide medication. He also complained about one of the doctors, and that when his mother was discharged she had an injury about which he believed staff had lied to him.

As part of our investigation we took independent advice from two advisers - one specialising in nursing and one in medical care of the elderly. We upheld both of Mr C's complaints. In relation to the overall medical management of Mrs A's Parkinson's disease, the advice we accepted was that in the main the care and treatment provided to Mrs A was reasonable. However, the medical adviser said that there was no evidence that the consultant reviewed Mrs A, and we can only reach a judgement based on the evidence available to us. In this case the evidence indicates that the consultant did not see and review Mrs A as they should have done. Referring to the nursing care provided, the advice we accepted was that while aspects of this were reasonable, there were failures relating to prescribed medication. Although there was no evidence that missing the medication had caused Mrs A harm, we considered that the failure to record why it was not dispensed or to note other actions (such as informing medical staff) was significant.

Recommendations

We recommended that the board:

- bring our medical adviser's comments about the doctor to their attention and ensure that the doctor reviews the clinical care of their patients as per their duty of care towards them and fully records this;
- bring the failures in record-keeping in relation to prescribed medication to the attention of relevant staff;
- amend their policy to outline procedures to be followed when prescribed medicines are not dispensed; and
- apologise to Mr C for the failures identified.