SPSO decision report

Case: **201301496, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment given to his father (Mr A). He said that the board failed to admit Mr A to hospital on two occasions, did not provide him with appropriate medication and infection control measures, and did not communicate appropriately with Mr A's family.

During our investigation, we took independent medical advice from an emergency medicine consultant, a consultant physician and a consultant microbiologist. The advice we received was that the decisions not to admit Mr A to hospital were reasonable, and that Mr A received appropriate medication on both occasions. However, we were concerned that on the first occasion the commencement of antibiotics (drugs to treat bacterial infection) was poorly managed, although we also noted that the board apologised and took action to address this. Our emergency medicine adviser said that there were no failings that would have impacted on the outcome, but commented on the board's action in relation to screening Mr A for sepsis (blood infection) and we made a recommendation about this.

We found that the antibiotics given to Mr A before he was admitted to hospital were appropriate. He also received appropriate antibiotic therapy when he was admitted and this was revised appropriately during his stay in hospital. Our consultant physician adviser said that the decision not to isolate Mr A when he was first admitted was reasonable and that he was later treated with appropriate infection control measures.

We were concerned that there were failures in communication with Mr A and his family, although we were aware that the board had accepted that in several areas communication had not been as they would have expected, and had apologised for this. We also noted that they had taken action to improve communication between medical staff and between hospital staff and relatives. We did not, therefore, find it necessary to make recommendations about this.

Recommendations

We recommended that the board:

- ensure that relevant staff members are made aware of our adviser's comments in relation to sepsis screening and given the opportunity to reflect on these for future practice.