SPSO decision report

Case: **201301808, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs A had a brain tumour. Two years after she was diagnosed with this, and after three epileptic seizures and a possible stroke, she was admitted to hospital. Mrs A's family were unhappy with her care and treatment while she was there and discharged her home early the next month. Mrs A died just under three weeks later. Mrs A's son (Mr C) complained about her care and treatment and the level of communication with her family while she was in hospital. He also complained about the way the board dealt with his subsequent complaint.

During our investigation, we gave careful consideration to all the relevant information, including all correspondence, meeting notes, Mrs A's clinical records and the board's complaints policy. We obtained independent advice from our nursing adviser and this too was taken into account.

Our investigation found that Mrs A's fluid and food intake was poor, but that the nursing notes showed that she was offered food and drinks. Our adviser said that while staff had clearly tried to improve her intake, it was often the case that very unwell patients were reluctant to eat or drink. Mrs A also had a thrush infection in her mouth, and this must have been difficult for her. We found that Mrs A's medication and pain relief were appropriate for her condition and she had been referred to the palliative care (care to prevent or relieve suffering) team. We also found that before Mrs A was discharged, a plan was put in place to support her at home. The records showed that staff had tried to keep the family regularly updated, but it was accepted that their efforts had not perhaps met the family's expectations and could be improved. Overall, we found that Mrs A's care and treatment was acceptable. However, we upheld Mr C's complaint about complaints handling, as after he complained there was clear evidence of delay.

Recommendations

We recommended that the board:

- offer a formal apology for the delay in dealing with the complaint.