SPSO decision report

Case: **201302881, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the end of life care and treatment provided to his late mother-in-law (Mrs A) in Glasgow Royal Infirmary. Mr C said that the family found it distressing to see Mrs A in the latter stages of her illness, and that the board failed to provide reasonable pain relief and refer her to the palliative care (care provided solely to prevent or relieve suffering) team within a reasonable time. He also said healthcare professionals failed to take account of the views of Mrs A's daughter, who held welfare power of attorney (a legal document appointing someone to act or make decisions for another person), and that there were failures in communication and record-keeping, particularly around the provision of a morphine pump. Finally, Mr C complained about the the way the board handled his complaint, saying that they failed to carry out an objective and transparent investigation.

Having taken independent advice from a medical adviser and a nursing adviser, we upheld some of Mr C's complaints, as we found that while the frequency of communication between healthcare professionals and the family was reasonable, the board did not ask Mrs A's family about power of attorney (particularly in light of Mrs A's incapacity) or formally discuss the medical procedures in advance with Mrs A's daughter. Having said that, we found that the board's records of several conversations with the family about the provision of a morphine pump were reasonable in that they reflected the views of the clinicians concerned. We accepted advice that Mrs A's pain relief and end of life care were generally reasonable and that Mrs A's symptoms were adequately managed by the medication prescribed. We were not, however, satisfied that the board's complaint investigation was carried out in accordance with the NHS complaints procedure, as it appeared from the board's responses that it was done by the members of staff who were the subject of the complaint.

Recommendations

We recommended that the board:

- review their patient profile and documentation and its completion in light of our nursing adviser's comments;
- bring the failures our investigation identified to the attention of the relevant healthcare professionals concerned;
- ensure the relevant healthcare professionals appropriately consider referrals to the palliative care team at the earliest opportunity, in light of our medical adviser's comments;
- bring the failures identified in complaints handling to the attention of relevant staff; and
- apologise to Mr C for the failures this investigation identified.