SPSO decision report

Case: **201603737, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C raised concerns about the care and treatment she received for urinary incontinence at a number of hospitals within the board's area.

Mrs C complained that there was a failure to provide her with a reasonable standard of care and treatment and a failure to provide her with a treatment plan. We took independent advice from a consultant urologist. We found that it was clear that Mrs C had struggled with severe urinary incontinence for several years. While the initial care and treatment that she received was managed correctly, there was subsequently unreasonable delays in her treatment and in providing her with an appropriate treatment plan. We therefore upheld these aspects of Mrs C's complaint.

Mrs C also complained that there was a failure to communicate with her appropriately about her treatment. The adviser found that the board had not been supportive of Mrs C, considering the unnecessary delays which she had experienced and the impact this had evidently had on her. The adviser concluded that, as Mrs C did not appear to have an understanding of the cause of her problem, she should have been offered an urgent discussion about this and should have been told about the best treatment to restore urinary control. We considered that this should have been recognised by the board at an earlier stage and we upheld this aspect of Mrs C's complaint.

Mrs C further complained that there was a failure by the board to respond to her complaint appropriately. The board accepted that their complaint response letter did not make it clear to Mrs C that they could only consider her treatment covering a specified period of time. We found that the board should have explained this to Mrs C and should also have explained the reasons why this was the case. Therefore, we upheld this part of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings identified in our investigation, including:
- delays in Mrs C's care and treatment
- a delay in providing Mrs C with an appropriate treatment plan
- failing to communicate with Mrs C appropriately about her treatment
- failing to respond appropriately to Mrs C's complaint
- The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Measures should be in place so that other patients are not affected similarly by delays in treatment.
- Measures should be in place so that patients are provided with a treatment plan without delay.

- Staff should be reminded of the need to be supportive and to show empathy to patients, where there are delays in treatment.

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.