SPSO decision report

Case: **201800064, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the palliative care and treatment that her father (Mr A) received at Queen Elizabeth University Hospital. Mr A was later transferred to a hospice where he died. Mrs C was concerned about the types and doses of medication prescribed to Mr A and the board's communication with the family about Mr A's condition and the medication he was receiving.

We took independent advice from a consultant in palliative medicine. We found that the majority of the palliative care and treatment that Mr A received was reasonable. However, we found that the handover between the hospital and the hospice could have been better. In particular, the hospice referral letter did not detail all the drugs that Mr A was receiving and it did not explain the reasons for the unusual combinations he was prescribed. Therefore, we upheld Mrs C's complaint about the palliative care and treatment that Mr A received.

In relation to communication from the board with the family, we did not find evidence that this was unreasonable. Therefore, we did not uphold this aspect of Mrs C's complaint.

Mrs C also complained about the nursing care that Mr A received. We took independent advice from a nursing adviser. We found that the majority of the nursing care was reasonable. However, we also found that the Nutrition Profile and Malnutrition Universal Screening Tool were not completed within 24 hours of Mr A's admission to hospital. On balance, we upheld Mrs C's complaint about nursing care.

Finally, Mrs C complained about the way the board handled her complaint. We found that:

• there was a delay in responding to Mrs A's complaint.

• the board did not agree a timescale with Mrs A about when she could expect to receive the minutes of a meeting about her complaint.

• the board's complaint response used generic terms and did not clearly explain what medication Mr A received, why the medication was changed, what the possible side-effects were and how these were monitored.

Therefore, we upheld Mrs C's complaint that the board failed to handle her complaint reasonably.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failure to clearly document the handover of Mr A's drug regimen to the hospice, the failure to complete the Nutrition Profile and Malnutrition Universal Screening Tool within 24 hours of Mr A's admission, the delay in responding to Mrs C's complaint, that no timescale was agreed with her about when she could expect to receive the meeting minutes and that the complaint response did not clearly

explain what medication Mr A received. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- The handover of patient drug regimens to other care providers should be clearly documented.
- Patients should receive adequate nutritional assessment and care planning in accordance with the relevant standards.

In relation to complaints handling, we recommended:

- Complaints should be handled in line with the model complaints handling procedure. The model complaints handling procedure and guidance can be found here: www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs.
- There should be an appropriate level of detail in complaint responses that can be clearly understood.