# SPSO decision report

**Case:** **201801262, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations

## Summary

Ms C complained about the care and treatment her mother (Mrs A) received when Mrs A was admitted to Queen Elizabeth University Hospital. Ms C considered that her mother's death could have been avoided if she had been provided with better care and treatment. Ms C complained that the board:

failed to provide reasonable care and treatment;

failed to advise the family regarding the correct procedure to follow when requesting clinical records;

failed to provide a reasonable response to the complaint; and

failed to respond to the complaint within a reasonable time.

We took independent advice from a clinical adviser. We found that Mrs A should have been seen by a more senior doctor during the four day period she was in hospital. We considered that a more senior doctor may have identified that the use of diclofenac (pain relief) in an elderly patient with renal impairment may affect the kidney function. They may also have identified a need to increase the use of steroids. Therefore, we upheld this aspect of Ms C's complaint. However, we noted that even if Mrs A had seen a more senior doctor this may not have changed the outcome for her.

In relation to procedure information, we found that the board had apologised for giving out incorrect information to the family which meant there was a delay in receiving clinical records.

In relation to complaints handling, we found that the complaint was made beyond the timescale for making complaints set by the board. However, the board decided to accept the complaint for investigation and they were therefore required to follow their complaint handling procedure. When the board responded to the complaint they failed to identify and advise the family that Mrs A had not seen a senior doctor more than once during her stay in hospital. We also found that correspondence on the complaint was ongoing for a period of almost nine months before a meeting was held. We considered that as many issues were being raised and the family were expressing concerns over a course of correspondence, there would have been merit in holding a meeting at an early stage to discuss concerns. Ms C could therefore have been signposted to this office sooner if the board considered they could do nothing further. We upheld these aspects of Ms C's complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to ensure Mrs A was seen by a more senior doctor on more than one occasion when she was in hospital and for failing to identify this during the board's own investigation of the complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at

www.spso.org.uk/information-leaflets.

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

- The board should review the process they have in place for regular review of patients by senior doctors and confirm the outcomes.
- The board should ensure they have a protocol on pain relief in elderly patients.

In relation to complaints handling, we recommended:

- A response to a complaint should be transparent.

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.