SPSO decision report

Case: **201801892, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment she received during two admissions to Galloway Community Hospital. Mrs C was admitted with abdominal pain and she was suspected to have sepsis (blood infection). We took independent advice from a consultant in acute medicine. We found that during Mrs C's first admission, there was a delay in administering her antibiotics and that she should have been given intravenous fluids (fluid through a drip). We also found that during both admissions there was an unreasonable delay in investigating and establishing the source of her underlying infection. We upheld this aspect of Mrs C's complaint.

Mrs C also complained about the follow-up care she received from the board in response to her ongoing abdominal pain. We took independent advice from a consultant colorectal surgeon (a specialist in conditions of the colon, rectum or anus). We found that reasonable steps were taken to investigate Mrs C's condition and she was given appropriate advice that surgery would not be appropriate treatment for her. We did not uphold this aspect of Mrs C's complaint. However, we gave feedback to the board about the potential benefit of offering out-patient follow-up for patients with complex and unresolved conditions like Mrs C.

Finally, Mrs C complained about the board's handling of her complaint. We found that there was a failure to update Mrs C during the board's investigation, which the board had acknowledged and apologised for. We also found that the board failed to investigate and respond to all aspects of Mrs C's complaint. Therefore, we upheld this aspect of Mrs C's complaint and we made further recommendations in relation to this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the unreasonable failings in her care and treatment and for the failings in the board's complaints handling. 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:

- When a patient is suspected to have sepsis, they should receive appropriate treatment, including the prompt administration of antibiotics.
- If a patient's diagnosis is unclear, there should be a system in place so medical staff can seek advice or a prompt review from a consultant.

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 at www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs.

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.