SPSO decision report

Case: **201807958, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the medical and nursing care she received at Queen Elizabeth University Hospital in relation to idiopathic (of unknown cause) intracranial hypertension (a condition associated with raised fluid pressure around the brain). The main medical points of concern related to the lack of pain relief in relation to a lumbar puncture (a procedure in which fluid is removed from the spinal canal for diagnostic testing or treatment); discharge from hospital without proper monitoring of the medication she was prescribed; and the lack of pain relief following a surgical procedure to drain fluid. The main nursing points of concern included refusal to remove a cannula (a tube that can be inserted into the body, often for the delivery or removal of fluid); the refusal of pain relief following the surgical procedure and the need to await a doctor; that she was not allowed to leave the ward; and was not assisted with either her personal care, eating nor drinking. Miss C also complained that the board did not respond to all the points of concern that she had raised in her complaint correspondence.

We took independent advice from a consultant neurosurgeon and a registered nurse. In terms of the medical care, we found that the pain relief prescribed both at the time of the initial lumbar puncture and following the surgical procedure were reasonable and appropriate; and that it was reasonable to discharge Miss C with medication pending further specialist review. We, therefore, did not uphold this complaint.

In terms of the nursing care, we found that there was insufficient evidence to support Miss C's concerns about removal of a cannula or that she was advised not to leave the ward. We found that there was evidence to support that Miss C's pain monitoring was reasonable and appropriate given her pain score was regularly assessed, her pain escalated to medical staff where appropriate and her pain management reviewed by pain specialist staff. We also considered that there was a lack of evidence to show that there were failings in the nursing care in relation to Miss C's personal care, eating or drinking. Therefore, we did not uphold this complaint.

We did, however, uphold Miss C's complaint that the board failed to provide a full, objective and proportionate response to her complaint in terms of the NHS Scotland Complaints Handling Procedure. We made a learning and improvement recommendation to the board in September 2019 as a result of a similar complaint about failing to provide a full, objective and proportionate response and have followed up on this recommendation to ensure its implementation.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for failing to respond to all of the points of concern that she raised. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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.