SPSO decision report

Case: **201907852, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained that the board's significant clinical incident investigation and complaint investigation unreasonably failed to identify all the failings regarding the care and treatment provided to their spouse (A). We took independent advice from a general surgeon. We found that the Significant Clinical Incident Review did not identify that:

it was unreasonable that no clinical observations or clinical review took place when A developed an acute onset of pain on the surgical ward;

it was unreasonable that A's case was not discussed earlier with a consultant on the surgical ward; and

it was unreasonable that a request for an urgent CT scan was not made earlier.

We upheld C's complaint in this regard and made recommendations to the board.

C also complained that the board failed to take reasonable action to address the failings identified following the significant clinical incident investigation and complaint investigation. We took independent advice from a nursing adviser with experience of working in and managing an Intensive Care Unit. We found that the board had taken reasonable action to address these failings. While we fully appreciated that actions taken by the board will not change A and C's experience, we were satisfied that learning and improvement had taken place which should prevent the same situations from arising again. We did not uphold C's complaint in this area.

We also considered how the board had handled C's complaint. We found that the board did not provide a revised timescale for when C could expect to receive the response to their complaint and made recommendations to the board in this regard.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to carry out a clinical observations or a clinical review when A developed an acute onset of pain on the surgical ward, failing to discuss A's case with a consultant earlier on the surgical ward, failing to request an urgent CT scan at the relevant time, and not providing a revised timescale for when they could expect to receive a response to their 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:

- Deteriorating patients should be escalated to a senior clinician especially in those with ongoing low blood

pressure. Where appropriate in these cases, a senior doctor should carry out a physical examination.
- Patients who have an acute onset of severe pain should be reviewed by a clinician and the findings should be documented.
- Significant Clinical Incident Reviews should be robust and, so far as is possible, identify all failings in clinical care to ensure there is appropriate learning and improvement.
- Urgent CT scans should be requested where a diagnosis of ischaemic bowel is being considered.

In relation to complaints handling, we recommended:

- Where the 20 working day timescale for a response cannot be met, the complainant must be kept updated on the reason for the delay and given a revised timescale for completion.

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.