SPSO decision report

Case: **202003625, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment their late parent (A) received at Queen Elizabeth University Hospital. A was admitted to hospital with a diagnosis of pancreatitis (inflammation of the pancreas). They were treated with fluids and antibiotics and their fluid balance was measured. They recovered and were discharged later that month. A was readmitted with various symptoms including abdominal pain, vomiting, loose stools and not eating or drinking on two further occasions and was discharged both times. A was later readmitted to the hospital in cardiac arrest and died shortly after arrival at the hospital.

We took independent advice from an appropriately qualified adviser. We found that the board failed to provide A with a reasonable standard of care and treatment. During one admission, there was a lack of comment on A’s hernia, a lack of investigation of low blood pressure and no evidence of a cardiology (specialists in diseases and abnormalities of the heart) input. On another admission, we found that the care and the management plan concerning A’s hernia was below standard and that there appeared to be a delay in the involvement of other specialists. We also found issues relating to the planning of surgery for A. Therefore, we upheld this aspect of C's complaint.

C also complained that A's final discharge from hospital was unreasonable. We found A's discharge to be reasonable and did not uphold this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for not making a timely assessment of risk for surgery, the failure to address A’s low blood pressure, the standard of monitoring and examination of A’s hernia, the delay in the involvement of clinical specialists, the standard of the management plan for A's hernia repair, the standard of planning of A's urgent surgery and for delays in surgery. 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 have a policy in place on the management of emergency cases and prioritisation to ensure delays and recurrent cancellations of cases are minimised.
- The board should review how deteriorating patients are managed to ensure timely involvement of relevant specialties in care when there are complex patients.
- Ward round documentation needs to reflect concerns and management plans clearly.

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.