SPSO decision report

Case: **202102676, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided by the board when they were admitted to hospital. C said that they had collapsed at home and were told on admission to hospital that they had an abscess on the muscle connecting their back and hip, which was treated with antibiotics. C said that their leg continued to swell and bruise and that the pain continued to get worse, resulting in their legs giving way on a number of occasions whilst in hospital.

C complained that the board failed to appropriately diagnose, assess and treat them and failed to arrange appropriate follow up care on discharge. C also complained about the communication from the board throughout their stay in hospital. In particular, C said that the board failed to adequately explain the treatment or care that they were provided with.

C also questioned the board's conclusion that their further admission to another hospital was not due to the issues that they experienced at the original hospital, but due to an INR issue (International Normalised Ratio: a test which measures the time for the blood to clot when taking Warfarin). C said that this is not what they were told by the hospital.

We took independent advice from a registered consultant physician. We found that there was a failure to provide appropriate follow up for C on discharge, including on-going pain management. There were also record keeping failures during C's admission to hospital, such as timings of C's review and ability to identify involved clinicians. We found that the diagnosis, assessment, treatment and follow-up care with regards to C's leg was not reasonable, and upheld this aspect of the complaint.

We found that the board's communication with C was unreasonable, specifically that there is a lack of evidence of adequate communication about diagnosis and treatment and also in relation to pain management and follow-up care. We upheld this aspect of the complaint.

We also found failings in the board's handling of the complaint, such as limited information being available to demonstrate that there had been a local investigation into the complaint. The board's response to the investigation questions posed by the SPSO was also limited. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Adequate medical records should be maintained including signed entries and the times of reviews in line with relevant guidelines. There should be clear documentation of relevant clinical subjective and objective findings to support the process of clinical reasoning and care planning.
- Patients should be discharged with appropriate follow up arrangements in place including for pain management where relevant and discharge documentation should be completed so that full discharge information is provided.

In relation to complaints handling, we recommended:

- The board's complaint handling, monitoring and governance system should ensure that failings and good practice are identified and that learning from complaints is used to drive service development and improvement. The board should ensure that full responses are provided when responding to SPSO enquiries.

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.