SPSO decision report

Case: **201508359, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained to us about the medical care and treatment provided to his late mother (Mrs A) in the Southern General Hospital before her death. We took independent advice on Mr C's complaint from a consultant in general and elderly medicine. We found that there had been a number of failings in the medical care provided to Mrs A. There were delays by medical staff in attending when her condition deteriorated. She should also have been seen by a more experienced doctor when nursing staff raised concerns about her condition. In addition, there were failings in relation to communication with Mrs A's family. Although we upheld this complaint, we were satisfied that the board had acknowledged that aspects of Mrs A's care were not adequate and had apologised for this. The board had also carried out a significant incident review and had made recommendations to address the failings.

Mr C also complained that Mrs A did not receive a reasonable standard of nursing care. We took independent advice on this aspect of Mr C's complaint from a nursing adviser. We also found that there had been a number of failings in relation to the nursing care provided and upheld this complaint. However, these failings had been identified by the board and they had made recommendations to ensure there was learning and improvement. They had also apologised to the family for the failings.

Finally, Mr C complained that there had been a delay in moving Mrs A to a critical care unit. We upheld this complaint as we found that Mrs A should have been moved to the critical care unit at an earlier stage and that the delay in doing so had been unreasonable. Although the board had introduced new criteria for medical referrals to the critical care unit, they did not have a written policy in relation to this.

Recommendations

We recommended that the board:

- provide evidence that the recommendations from their significant incident review have been implemented;
- provide evidence that they have considered what the role of a first year trainee doctor should be in cases where there has been a serious deterioration in a patient;
- formalise the criteria now in place for medical referrals to the critical care unit in a written policy; and
- issue a written apology to Mr C for the delay in transferring Mrs A to the critical care unit.