SPSO decision report

Case: **201703029, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment that her mother (Mrs A) received when she attended the emergency department at Queen Elizabeth University Hospital. Mrs A attended the hospital with severe headaches and pain radiating down her face and mouth. Ms C said the consultant who dealt with Mrs A failed to consider her reported symptoms properly, failed to carry out a thorough physical examination of Mrs A and instead referred Mrs A to her GP.

We took independent medical advice from a consultant in emergency medicine. We found that as Mrs A did not present with features of an immediate life threatening condition, it was safe and reasonable to redirect her to her GP. However, we found that the triage process (the process for sorting patients in an emergency department according to urgency) for patients presenting with headache was not followed in Mrs A's case, and information which should have been obtained and recorded was not. The board should also have provided Mrs A with a redirection leaflet which explained the redirection process. On balance, we considered that the board did not provide Mrs A with appropriate care and treatment and we upheld this part of the complaint.

Ms C also complained that the board unreasonably failed to send a report to Mrs A's GP following her attendance at the hospital. We found that the board should have sent a letter to Mrs A's GP, but failed to do so. Therefore, we upheld this part of the complaint.

Ms C also complained that the board unreasonably delayed in responding to her complaint. The evidence showed that while there were delays in obtaining formal consent from Mrs A for Ms C to make a complaint on her behalf, there were also unreasonable delays by the board in their handling of Ms C's complaint. Therefore, we upheld this part of the complaint.

At the beginning of our investigation into this complaint, the board failed to provide us with the correct version of their redirection policy which resulted in a delay in our decision making. Therefore, we made a recommendation to the board in light of this.

Recommendations