SPSO decision report

Case: **201704139, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, an advocacy worker, complained on behalf of her client (Mrs B). Mrs B was concerned about the care and treatment her husband (Mr A) received during his admission to Queen Elizabeth Hospital. Mr A had suffered a broken neck in an accident and he was being treated with a neck brace. Ms C's main concern related to Mr A swallowing his dental plate and explained that this was not discovered for almost two weeks even though Mr A had a sore throat and difficulties swallowing. Ms C also complained about the nursing care and that there was inadequate communication with Mr A's family. In particular, when his condition deteriorated and he was thought to have sepsis (a blood infection). Finally, Ms C complained that the board's handling of the complaint was unreasonable and that no significant clinical incident review was carried out.

We took independent advice from a consultant orthopaedic trauma surgeon (a surgeon who diagnoses and treats a wide range of conditions of the musculoskeletal system) and a registered nurse. The board considered that swallowing a dental plate was a very unusual occurrence so it was reasonable this was not suspected by hospital staff. We found that the medical treatment initially received for Mr A's swallowing and eating difficulties was appropriate. However, we found there was an unreasonable delay in referring Mr A to ear, nose and throat and this delayed the discovery of his swallowed dental plate. We upheld this aspect of Ms C's complaint.

In relation to the nursing care received, we found that Mr A was given a reasonable level of personal care and his food input and fluid intake was appropriately monitored by staff. We noted that nursing staff recognised Mr A's difficulties swallowing and eating and made appropriate referrals. Therefore, we did not uphold this aspect of Ms C's complaint.

In relation to communication, we found that communication with Mr A's family was not to the appropriate standard. We upheld this aspect of Ms C's complaint. However, we noted that the board had acknowledged this failing and had apologised to Mrs B.

Finally, we found that the board failed to commmunicate clearly about meeting to discuss the complaint or about the significant clinical review and it's findings. We upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs A for the delay in making the referral to ear, nose and throat; and for the failings in their communication about meeting with her and about the significant clinical incident review. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.
- Provide Mr A's family with a copy of the significant clinical incident review.

What we said should change to put things right in future:

- Ensure there is appropriate communication with patients and/or their families during, and at the conclusion of, significant clinical incident reviews.

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.