SPSO decision report

Case: **201804880, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her late father (Mr A) at the Royal Alexandra Hospital. Mr A had dementia and was admitted with drowsiness, fever, confusion, and crackles in the lung. Ms C felt that there was not sufficient screening for sepsis when Mr A was admitted, that he was not given appropriate pain relief, and that discharge was unreasonable. Ms C also raised concerns about the nursing care provided to Mr A.

We took independent advice from a consultant in acute and general medicine, and from a nurse. We found that Mr A was appropriately assessed when he was admitted to hospital, that his pain was managed appropriately, and that his discharge was reasonable. We did not uphold this aspect of Ms C's complaint.

In relation to nursing care, we found that whilst there were some areas of nursing care which were reasonable, there were a number of failings. Namely, we found that there was limited evidence of care planning being carried out appropriately, there was no 'Getting to Know Me' document completed (this document should be completed for all patients with dementia). We also considered that a non-verbal pain assessment tool should have been used, but noted that the board had acknowledged this. We upheld this aspect of Ms C's complaint.

Ms C further complained about communication and complaints handling. We found that there was a failure to appropriately communicate with Ms C when her father was in hospital, particularly as she was his power of attorney and next of kin, and we upheld this aspect of her complaint. We also found that in relation to complaint handling, there was confusion regarding whether Ms C's complaint was in fact feedback, and this resulted in a delay in acknowledging the complaint. We also found that the response was delayed and the reasons for this were not clear. We upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to provide Mr A with reasonable nursing care and treatment; failing to communicate reasonably; and failing to handle Ms C's complaint reasonably. 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:

- Appropriate care planning should be carried out and should take into account the specific needs of patients with dementia.
- A 'Getting to Know Me' document should be completed on admission for all patients with dementia.
- Communication with relatives should be proactive, well documented, and should appropriately involve the input of power of attorneys and next of kin.

In relation to complaints handling, we recommended:

- Prompt action should be taken to determine whether someone is making a formal complaint.
- Complaint acknowledgement letters should be sent out as per the complaints handling procedure.
- Responses should be sent where possible within 20 days and without undue delay in line with the board's complaint handling procedure.

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.