SPSO decision report

Case: **202206606, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received from the board. In particular, C complained that the board failed to adequately investigate their presenting symptoms of pain and nausea, or keep adequate medical records during an attendance at the Surgical Immediate Assessment Unit (SIAU).

Following their attendance, C wrote an account of their experience on Care Opinion (an independently operated platform for individuals to post comments about their care experiences). The board contacted C in response to their post asking that they write to them about their concerns. Despite doing so, C said that they did not receive a response from the board, and that they subsequently submitted a formal complaint through the board's complaints handling procedure.

The board's response to the complaint said that C had been assessed properly and that the clinical findings did not indicate that further investigation was required. The board acknowledged that C had not been seen by a senior clinician as planned, however, they noted that they had left the SIAU against advice before they were able to see C.

We took independent advice from a consultant general and colorectal surgeon. We found that C did not receive an adequate clinical examination. We found that the documentation of this encounter was unreasonable, noting that there was little information relating to the discussion which took place with a senior clinician, and no documentation of the worsening advice given to C. As C had already followed a 4-week plan by their GP to 'watch and wait' without any improvement in their symptoms, it was unreasonable to discharge C without undertaking or planning further investigation at this time. It was also noted that the emergency and final discharge letters from this attendance were not sent until several months after this attendance. We upheld this aspect of the complaint.

In relation to the board's handling of C's complaint, we noted that C had first posted a comment about their experience on Care Opinion. C later complained to the board directly when they did not receive a response, despite the board contacting them about their Care Opinion post. Once C had made a formal complaint via the board's complaint process, we found that this had been timeously managed in keeping with the board's complaint handling procedure. While we noted some factual inaccuracies in the board's letter of response to C, we were otherwise satisfied that a reasonable investigation of the complaint had taken place. We did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in relation to the physical examination and assessment that they received at the SIAU, and in relation to the documentation of the episode of care. 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:

- Medical records should clearly and accurately document consultations with patients, including where senior advice or guidance has been sought. Decisions regarding discharge and worsening advice should be documented. All entries should be signed and dated and, where appropriate, the record should identify the name of the person providing senior clinical advice.
- Patients should be offered a chaperone, and the decision should be documented in the medical record.
- Staff should introduce themselves to patients by name and grade.
- Patients should be assessed and examined appropriately in keeping with their presenting symptoms and relevant past medical history.

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.