SPSO decision report

Case: **202304314, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (B) about the care and treatment provided to B's late family member (A) during their admission to hospital. In particular, in relation to pain management, standard of care and communication.

In response to the complaint, the board apologised for the failings identified in nursing care and communication. As a result of the failings the board had taken action. This included reiterating the importance of following the National Early Warning Score (NEWS) policy, reminding nursing staff of their obligations to comply with their code of professional conduct in the workplace, and reflecting on A's care for the purpose of improving person centred care. B was dissatisfied with the board's response and brought their complaint to the SPSO.

During our investigation, the board accepted that aspects of A's care and treatment should/could have been better and explained that reflection had taken place, and learning had been taken forward for the purpose of improving the level and standard of person-centred care provided to other patients. In addition, relevant staff had been given the opportunity to reflect on their communication with A's family.

We took independent advice from a consultant general and colorectal surgeon (specialist in in conditions in the colon, rectum or anus). We found that there had been a number of failings in the care and treatment A received. In particular, we found that there had been a delay in carrying out a CT scan and in diagnosing that A had a bowel obstruction. We found that this may have impacted on their management, including giving consideration to conservative/non-surgical intervention. We also found that A's pain management had been unreasonable and that an adverse event review should have been conducted, particularly around a diagnosis of bowel obstruction and its management. In view of the failings identified, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for these failings. 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:

- There should be appreciation and awareness of analgesic requirements in patients with suspected mechanical bowel obstruction and on long term medications for chronic pain.
- There should be appreciation and awareness of a diagnosis of mechanical bowel obstruction and its timely management including the use of Gastrograffin (ASGBI guidelines) and NELA score.

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.