SPSO decision report

Case: **202405542, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

C complained about the treatment that the board provided to their late spouse (A) during a lengthy hospital admission. A's agitation and delirium was treated with anti-psychotic medication and sedatives. A was later discharged to a care home.

C was concerned about the amount and appropriateness of the anti-psychotic medication and sedatives administered to A. They also highlighted what they considered to be inaccuracies in the recording of the medication administered and felt A was unreasonably discharged.

We took independent advice from a consultant in old age psychiatry. We found that the type and amount of medication administered was in keeping with prescription guidelines and accepted clinical practice. Medication was also reasonably prescribed and adjusted after appropriate consideration of A’s history and symptoms. Therefore, we did not uphold this part of C's complaint.

In respect of record keeping, we found that there was no firm evidence to indicate staff unreasonably failed to record medication on the electronic recording system. We recognised that there may appear to be discrepancies between what was on the online system and what was documented in the written notes. However, factors such as non-contemporaneous recording and separate medical/nursing records can account for this. As such, we did not uphold this part of C's complaint.

Finally, we found that A's discharge was based on an appropriate consideration of their overall health, including delirium. Therefore, it was reasonable to conclude that A’s ongoing health could be managed in a care home setting. We did not uphold this part of C's complaint.