SPSO decision report

Case: **201305465, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her stepfather (Mr A) during his admissions to Gartnavel General Hospital and the Western Infirmary, Glasgow. She was unhappy about the standard of nursing care and the medical treatment Mr A received. Mrs C said there were delays in admitting Mr A and, once admitted, he was not properly cared for and nursing staff did not take his disabilities into consideration. Mr A was discharged from his first admission with a diagnosis of cancer, which proved to be incorrect, and there was a substantial delay in providing the correct diagnosis. The family said that this diagnosis came too late, as Mr A passed away some weeks later. Another of the board's departments then contacted them, offering assistance with Mr A's proposed discharge home, which added to their distress.

We took independent advice on this case from a nursing adviser and a medical adviser. We found the board had already acknowledged and apologised for a significant number of failings in Mr A's nursing care, and had provided evidence of what they had done to stop this happening again. Our nursing adviser said that Mr A's care was clearly substandard, but the board had demonstrated they had taken this seriously and had responded by taking proportionate and reasonable steps. Our medical adviser said that although Mr A's cancer diagnosis was not unreasonable, the delay in providing a conclusive diagnosis breached Scottish Government targets and that the board had not addressed this. We concluded that Mr A had experienced failings in nursing care, and in communication with the family, but that the board had taken reasonable steps to address these issues. They had not, however, identified that there was a failure to provide a follow-up appointment for Mr A following the cancer diagnosis.

Recommendations

We recommended that the board:

- provide evidence they have taken steps to identify the cause of the delay following Mr A's referral;
- provide evidence they have taken steps to ensure the delay experienced by Mr A when waiting for a follow-up appointment could not reoccur;
- provide evidence that they have taken action to ensure community-based staff are informed timeously of a patient's death; and
- apologise in a simple unqualified way for the failings our investigation identified, and the distress experienced by Mr A's family.