

SPSO decision report

Case: 201404658, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about aspects of the medical and nursing care and treatment provided to his brother (Mr A) during four admissions to Glasgow Royal Infirmary. Mr A was diagnosed with lung cancer. His deterioration was sudden and significant, and he died within four weeks of diagnosis. Mr C said that Mr A's cancer was not diagnosed within a reasonable time, and that his various discharges and the management of his pain was not reasonable. Mr C was particularly concerned about an attempt to resuscitate Mr A when they had agreed with nursing staff the night before that, as he was at the end of his life, he should not be resuscitated. Mr C also said that communication with nursing and medical staff was not reasonable, and that the family had explained to staff that they should be present when staff talked to Mr A because he had a fear of hospitals.

After taking independent advice from one of our medical advisers, we found that the treatment decisions and discharges were reasonable, as was the time it took to diagnose Mr A's cancer. Also, we could not reconcile the different accounts of the level of pain Mr C said Mr A experienced in light of the evidence from the medical records. However, in relation to the attempted resuscitation, we found that there were significant failings which resulted in a serious injustice to Mr A and his family, who were traumatised by the attempt. We also found communication failures between nursing and medical staff, which then affected communication with the family.

Recommendations

We recommended that the board:

- bring to the attention of relevant staff the medical adviser's comments in relation to senior clinical review for distressed patients at the end of their lives;
- review their process in relation to end of life care to ensure that inappropriate CPR (cardiopulmonary resuscitation) attempts are avoided;
- bring the shortcomings in record-keeping to the attention of relevant staff;
- ensure the failures around the attempted resuscitation are raised with relevant nursing staff in the annual appraisal process;
- ensure the failings in communication are raised with relevant staff in the annual appraisal process;
- take steps to ensure the involvement of senior clinicians with seriously ill patients and their families in light of the medical adviser's comments; and
- apologise for all the failings this investigation identified.