SPSO decision report

Case: **201600572, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mrs B) about the care and treatment her father (Mr A) had received at the Queen Elizabeth University Hospital before his death. We took independent advice on the complaint from a consultant in acute medicine. Mr A had been diagnosed with cancer and Ms C complained that he had been discharged from the hospital on two occasions, despite the fact that he was still very ill. Ms C also said that there had been a delay in carrying out a biopsy. We found that it had been reasonable to discharge Mr A on the first occasion and that there had not been an unreasonable delay in carrying out the biopsy. However, it had been unreasonable to discharge Mr A on the second occasion, as he had not been medically reviewed for at least two days at that point, despite concerns being raised about his fitness for discharge.

We also found that medical staff should have been clearer about Mr A's poor prognosis and likelihood of death. Some of the communication with his family had not been reasonable and as a result, they not been prepared for his death. The board had already apologised to the family for this. There should also have been better communication between the oncology and respiratory teams and a more realistic assessment of Mr A's fitness for chemotherapy. In view of these failings, we upheld this aspect of Ms C's complaint.

Ms C also complained about the nursing care Mr A had received. We took independent advice on this complaint from a nursing adviser. Although there were problems with replacing Mr A's water, we found that the nutritional care and personal care provided to Mr A had been reasonable. Whilst a nurse had incorrectly told Mrs B that her father was nil by mouth, the nurse had then phoned her back to apologise for this. We also found that the pain relief provided to Mr A had been reasonable and we did not uphold this aspect of the complaint.

Recommendations

We recommended that the board:

- issue a written apology to Mrs B for the failings in relation Mr A's discharge from hospital on the second occasion; and
- provide evidence that the failings identified in this investigation have been fed back to the staff involved in Mr A's medical care.