SPSO decision report

Case: **201602909, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mr A) about the care and treatment he had received before being diagnosed with colorectal cancer. Mr A had previously had a colonoscopy (an examination of the bowel with a camera on a flexible tube) and was diagnosed with diverticulosis (disease of the colon). He subsequently had a bowel screening test, which showed hidden blood in his bowel motion. He was initially told that a colonoscopy was the best way to look for the cause of bleeding, which in some but not all cases, may be due to bowel cancer. However, he was then told that a further colonoscopy would not be necessary.

Mr A subsequently attended his GP with abdominal pains and diarrhoea. He was referred to a general surgery clinic at Gartnavel General Hospital and an upper gastro-intestinal endoscopy (a medical procedure where a tube-like instrument is put into the body to look inside) and flexible sigmoidoscopy (a procedure that is used to look inside the back passage and lower part of the large bowel) were arranged. It was recorded that these showed mild gastritis (when the lining of the stomach becomes inflamed after it has been damaged) and that it was likely that diverticular disease (a group of conditions that affect the colon) had caused the positive bowel test.

Mr A continued to have abdominal pain and a scan of his abdomen and pelvis was arranged. This showed an area of thickening in a part of his colon, which either represented a tumour or diverticulitis. A further colonoscopy was then carried out and Mr A was subsequently diagnosed with cancer.

We took independent advice on the complaint from a consultant general and colorectal surgeon. We found that although it had taken some time to diagnose his cancer, there had not been any failings by the board and the timings in relation to each step of his care and treatment had been reasonable. The decision not to initially carry out a second colonoscopy had been in line with national guidance, which said that this should not be done where the patient has had a colonoscopy in the previous 12 months. We did not uphold this aspect of the complaint.

Ms C also complained that the board's response to her complaint incorrectly stated that a specialist nurse had told Mr A that he should see his GP for referral to his local colorectal service. Mr A disputed this and there was no record in his notes of what, if anything, the nurse told him. It was therefore difficult for us to comment further on what information the nurse gave Mr A. However, we found that the failure to record the advice given to Mr A was unreasonable and we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise that there are no contemporaneous notes in the records of what the nurse told Mr A. This apology should comply with SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- The board should consider how they wish the clinical nurse specialists to communicate with primary care and with patients and how they will record this information, when decisions are made within the screening service not to proceed with investigation.

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.