SPSO decision report

Case: **201606186, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A) when he was admitted to the Queen Elizabeth Hospital for surgery to treat prostrate cancer. In particular, she complained that the board unreasonably failed to identify possible complications of the surgery given Mr A's medical history. We took independent advice from a consultant urological surgeon. We found that the decision to offer the surgery to Mr A had been thought through in detail, and that every effort had been made to minimise the risk of bowel damage when carrying out the surgery. We also found that the consent form signed by Mr A referred to specific risks and complications associated with the surgery. Whilst we were concerned about aspects of record-keeping, the advice we received from the consultant urological surgeon was that, in recognising the possible complications of the surgery, the clinicians caring for Mr A had taken into account his medical history. We did not uphold this complaint.

Mrs C also complained about the nursing care and treatment Mr A received. We took independent nursing advice. We found that the nursing records were comprehensive and detailed and highlighted that the nursing care Mr A received was reasonable. As such, we did not uphold the complaint.

Mrs C also raised concern that the board had failed to identify the deterioration of Mr A's condition as early as they should have. We found that there was a delay in medical staff reviewing Mr A, and that consultant input should have been sought when Mr A's condition deteriorated. We also found that the level of communication with Mrs C was unreasonable when Mr A's condition deteriorated and there was a possibility of transfer to intensive care. In view of the failings identified we upheld this complaint.

Mrs C also complained that the board failed to provide a reasonable standard of treatment when complications were identified. We found that the clinicians caring for Mr A failed to acknowledge or act on a scan and x-ray finding in a timely manner, and as a result failed to recognise there was a possible bowel perforation. We upheld this part of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Make a formal apology to Mrs C for the shortcomings identified in relation to the care and treatment Mr A received.

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

- Relatives should be informed when a patient deteriorates.
- There should be appropriate escalation of deteriorating patients.
- There should be a system for communicating and acting on urgent results by clinicians in the relevant departments.

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.