SPSO decision report

Case: **201705031, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C, an advocacy and support worker, complained on behalf of Mrs B about the care and treatment provided to her late husband (Mr A) at Inverclyde Royal Hospital. Mr A was referred to the hospital for a scan of his urinary tract. A blockage was found and subsequent investigations identified an inoperable bladder tumour. Palliative treatment was planned for Mr A and he had a number of scans carried out over the following months. Mr C complained about the reporting of Mr A's scans, palliative care support and communication between staff and with Mr A and Mrs B.

We took independent advice from a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans), a palliative care nurse and a consultant urologist (a doctor who specialises in the male and female urinary tract, and the male reproductive organs). We found that there had been errors in reporting the extent/spread of Mr A's cancer and also in relation to a possible bowel perforation. We upheld this aspect of Mr C's complaint, however, the errors were unlikely to have affected the clinical treatment that Mr A received.

In relation to the palliative care support provided to Mr A, we found that there had been reasonable palliative care whilst Mr A was in hospital. However, there were issues with the referral process and access to community palliative care support. The board had already identified failings in palliative care support and apologised following their own consideration of the case. We upheld this aspect of Mr C's complaint.

Finally, we found that the board had acknowledged there were failings in relation to communication when Mr A was referred to another treatment centre and that they had offered apologies. We were also concerned that it was unclear from the case notes that the situation regarding prognosis and palliative care had been communicated and understood by Mr A and Mrs B. Therefore, we upheld this aspect of Mr C's complaint.

Recommendations

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

- Consideration should be given to issuing a report addendum when additional significant features are identified after review of medical imaging by the multidisciplinary team.
- Consideration should be given to issuing a report addendum if the interpretation of a medical image alters significantly from the previously issued report, following discussion with the referring clinician.
- Reporting errors should be discussed at imaging discrepancy meetings.
- There should be clearly defined referral criteria and process in place for discharge home from hospital for palliative care patients. Consideration should be given to using a discharge/transfer of care checklist.