SPSO decision report

Case: **201707514, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment her husband (Mr A) received at Inverclyde Royal Hospital and Royal Alexandra Hospital. Mr A was admitted with suspected empyema (pockets of infected fluid in the chest) and sepsis (a severe complication of infection). However, he was later found to have widespread cancer. After his discharge home, Mr A's condition worsened very quickly and he died the following week.

Mrs C complained that the board failed to provide Mr A with reasonable clinical care and treatment for his infection and/or sepsis. We took independent advice from a consultant respiratory physician (a doctor who specialises in treating and managing patients with conditions affecting their lungs). We found that as Mr A was suspected to have empyema, there was a significant delay in carrying out his pleural tap (where a small needle or thin tube is used to remove excess fluid from around the lungs). This delay had been identified and acknowledged by the board. We upheld this aspect of Mrs C's complaint and made further recommendations in relation to this.

Mrs C also complained that the board failed to provide Mr A with reasonable nursing care in relation to pain management and nutrition. We took independent nursing advice. We did not find evidence of failings in how Mr A's pain was managed. However, we found that there was an unreasonable delay in carrying out Mr A's nutritional assessment and failings in how his fluid balance was recorded. We upheld this aspect of Mrs C's complaint.

Mrs C raised concerns about the board's communication with Mr A's family, in particular about his diagnosis of cancer. As the board acknowledged inadequacies in how the diagnosis was communicated, we upheld this aspect of the complaint. However, we found that the board had already taken appropriate action to address this and made no further recommendations.

Mrs C also complained that the board unreasonably discharged Mr A home and without a suitable care package in place. We found it was reasonable Mr A was discharged home. However, we found that the board should have offered Mr A support at home given his diagnosis of widespread cancer. Therefore, we upheld this aspect of the complaint. We found that the board had appropriately apologised to Mrs C for this but we made a recommendation for further action.

Mrs C also raised concern that the board failed to send Mr A's medical records to another health board. The board accepted the medical records should have been sent and we upheld this aspect of the complaint. We found that the board had taken action to address this and made no further recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in aspects of Mr A's nursing care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Patients suspected to have an empyema should receive timely pleural fluid sampling to clarify their diagnosis.
- Fluid balance charts should be completed fully for all patients, including those who are independent, or the reason why it is considered unnecessary should be clearly recorded.
- Patients diagnosed with cancer should be offered support from a specialist cancer nurse and/or community services.
- When a patient is discharged with cancer that cannot be treated, their GP should be informed so they can provide and/or arrange appropriate support.
- Patients should have a MUST (Malnutrition Screening Tool) assessment within 24 hours of their admission to hospital.