SPSO decision report

Case: **201901337, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their spouse (A) about the care and treatment that they received from the board.

A initially presented with a locally advanced cancer which at the time of presentation had already spread to their lymph nodes. A underwent treatment, however, went on to develop progressive disease in their lymph nodes and also evidence of spread to the bone. While further treatment was given, A's general condition deteriorated and after a number of admissions to hospital, A died of a progressive cancer.

C raised concerns that the board had failed to provide reasonable, timely and appropriate medical care and treatment to A during their admission to the treatment centre.

We took independent advice from an oncologist adviser (cancer specialist).

We found that the treatment A had received conformed to current guidelines from the European Urology Association and Medical Oncology Associations, and overall, we found that the management of A's care was reasonable and that there were no significant failings in relation to the care and treatment given to A. However, we found that, while there was little, if no, evidence that earlier CT scans would have influenced the final outcome, given the circumstances of A's case, the CT scans carried out could have been done sooner.

With regard to C's concerns about the way that A's prognosis was communicated to them, while we found that overall the communication had been reasonable, we acknowledged that the method of communicating A's diagnosis to them had not met their needs and we provided feedback to the board about this.

While we found that the majority of the care and treatment given to A was reasonable, given that the CT scans could have been done sooner, on balance, we upheld this complaint.

C also raised concern about the medical care and treatment given to A during their admission to hosptial. In particular, that there had been clinical failures to pay attention to which medications had previously failed, which led to the same medications being prescribed to A again. Also, that there had been an unnecessary delay in moving A to the hospice.

We took advice from an independent oncology adviser. We found that A had been treated with appropriate anti-cancer therapies and symptoms relieving treatments, that the choice of antibiotics had been reasonable and that there had been no unreasonable delay in transferring A to the hospice.

We considered that the overall care and treatment provided to A was reasonable. As such, we did not uphold this complaint.

C also complained that the nursing care and treatment given to A in the hosptial had been unreasonable. We took

independent advice from a nursing adviser. We found that a number of aspects of the nursing care and treatment given to A had been reasonable and that, in particular, the nursing care provided for A had been delivered in a person centred way. However, we considered that it would have been reasonable to expect that a skin assessment to establish the extent of any skin damage would have been carried out and documented prior to A's move to the hospice, especially given that A was a high risk patient at end of life care. We considered that this aspect of A's nursing care was unreasonable and therefore on balance we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this case. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- In patients presenting with significant symptoms, the need for an urgent referral for a CT scan should be considered.
- Pressure area care should be given in line with National Institute for Health and Care Excellence (NICE) Clinical guidance CG179.

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.