SPSO decision report

Case: **201507790, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mrs A) that there had been an unreasonable delay in diagnosing that Mrs A's husband (Mr A) had cancer. Mr A had been admitted to the Southern General Hospital with breathlessness and swelling in his right leg. His condition deteriorated over the next few weeks and a number of tests were carried out. One month after he was admitted to hospital, it was confirmed that Mr A had metastatic cancer (cancer that spreads to other parts of the body).

We took independent advice from a consultant respiratory physician. We found that although the speed of investigation was timely during the first three days of Mr A's admission, there was then an unreasonable delay in carrying out further investigations and medical staff had not acted in line with the relevant guidance. An earlier diagnosis would have meant that Mr A and his family would have known the prognosis and likely outcome earlier. Palliative care could also have been considered at an earlier stage, although we found that curative systemic treatment (treatment such as chemotherapy that reaches cells throughout the body by travelling through the bloodstream) would not have been appropriate for Mr A. We upheld this aspect of Ms C's complaint.

Ms C also complained that staff had failed to ensure that Mr A had appropriate pain management. We found that although there was a good record of pain assessment within the nursing notes, there were numerous inconsistencies between the nursing and prescription records. We found that the pain management and escalation of pain relief treatment had not been in line with the relevant guidance and, in view of this, we also upheld this aspect of Ms C's complaint.

Recommendations

We recommended that the board:

- provide this office with an action plan detailing the steps that will be taken to prevent similar failings in future cases and to ensure that staff act in line with the relevant guidance;
- provide evidence that steps have been taken to ensure the involvement of palliative care specialist services at the appropriate stage in cases of this nature; and
- issue a written apology to Mrs A for the failings identified.