SPSO decision report

Case: **201605325, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, an advocacy and support worker, complained on behalf of her client (Ms B) about the care and treatment provided to Ms B's daughter (Miss A) in the final months of Miss A's life. Miss A had Fanconi anaemia (a genetic disease that can lead to bone marrow failure and cancer) and had a complex medical history of complications following a bone marrow transplant. Miss A received treatment at the Beatson West of Scotland Cancer Centre over a number of admissions. She was treated for numerous health issues, including a bowel condition.

Ms C raised concerns that staff failed to inform the family of the severity of Miss A's bowel condition. We took independent advice from a consultant haematologist and from a registered nurse. We were unable to find evidence that staff had discussed with Miss A, or Ms B, the severity of Miss A's bowel condition. We concluded that communication with the family was poor and we upheld this complaint.

Ms C also complained that the board did not provide a reasonable standard of treatment during Miss A's final admission. We found that the treatment provided for Miss A was in line with the relevant guidance, but the advice we received was that no consideration appeared to have been given to the fact that Miss A was dying and needed palliative therapy to keep her comfortable. We found that this was unreasonable and we upheld this complaint.

Ms C also raised concern that the board did not make reasonable transport arrangements when Miss A was discharged on one occasion when she became unwell in the car of a volunteer driver. We found that Miss A was noted to be well prior to discharge, and that it seemed that she became suddenly unwell during the journey. We were satisfied that the transport arrangements in place were reasonable and we did not uphold this complaint.

Finally, Ms C complained that the board refused to admit Miss A on one occasion when Ms B called the hospital in the early hours of the morning. The advice we received noted that Miss A was advised to attend the clinic later that day, but to call back if she became more unwell. The adviser did not find evidence that admission was requested and considered that the board's advice in this situation was reasonable. We did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise for the failure to communicate with Ms B and Miss A reasonably about the severity of Miss A's bowel condition and for the failure to provide palliative care and support to Miss A at the end of her life. 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 should be provided with any information on their condition that they want or need to know in a

way that they can understand. This should be communicated in a way that is considerate to those close to the patient. Staff should be sensitive and responsive in giving patients and families information and support. Communication with patients and their family members should be documented.

- Patients who are approaching the end of their life should receive high-quality treatment and care that supports them to live as well as possible until they die, and they should be supported to die with dignity.

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.