SPSO decision report

Case: **201906201, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their adult child (A). A was admitted to the Royal Alexandra Hospital via A&E after four weeks of diarrhoea and vomiting where they were diagnosed with Crohn's disease (a long-term condition that causes inflammation of the lining of the digestive system). It was suggested for A to have medical treatment with infliximab (a medication used to treat autoimmune disorders) which might prevent the need for surgery. This was prescribed for A and A was discharged to receive the second dose at an out-patient clinic. When A attended the out-patient clinic for the second dose, the hospital would not administer it as A had an existing infection.

A was re-admitted to hospital and a dose of infliximab was given. A was told that as they had not responded to infliximab, the board would perform a sub total colectomy (a surgical procedure to remove all or part of the colon) which would be reversible after 12 months. A had their surgery and a few days later their condition deteriorated and they required emergency surgery. It was found that A had a duodenal peptic ulcer (an open sore inside the lining of the stomach or small intestine) which had burst and caused sepsis (a serious reaction to infection). C complained about the medical and nursing care that A received.

We took independent advice from a consultant gastroenterologist (a physician who specialises in the diagnosis and treatment of disorders of the stomach and intestines) and a nursing adviser. We found that there was a lack of clarity about whether the first infliximab dose was administered, the second dose was unreasonably delayed, there was miscommunication about A's surgery and concerns about how A's condition was monitored overnight when their condition deteriorated. There also was no evidence that a medical/surgical review had taken place when it should have. Therefore, we upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for unreasonable care and treatment provided to A, communication failures and the lack of clarity about whether key medication was administered. 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:

- The board should ensure staff are aware of how the error in communication occurred and how to prevent a reoccurrence.
- The board should reinforce the national guidelines 'Professional Guidance on the Administration of Medicines' RPS & RCN Jan 2010 and local policy 'Safe and Secure Handling of Medicines in Wards, Theatres and Departments' NHSGGC 2008 (currently under review).

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.