SPSO decision report

Case: **202106577, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received whilst in hospital. A was admitted to hospital with light headedness, dizziness, and pain in the hip and leg. C had concerns about the board's failure to consider A's previous medical history, decisions made during surgery, communication, care provided, and what was recorded on the death certificate.

The board said that investigations into A's blood loss found no issues and that they planned to discharge A. However, due to further bleeding A was not discharged and required emergency surgery. A was made aware of the risks associated with the surgery. This operation was successful, however, a further procedure was required to remove a section of A's bowel. Due to further changes in A's condition, the board moved A to palliative care.

We took independent advice from a consultant in intensive care and acute medicine, a general surgery consultant and a registered nurse. We found that A's care and treatment was reasonable. However, A's medical history was recorded incorrectly by medical staff, affecting the treatment plan, investigations, and diagnosis. We found that A's operations were carried out reasonably. However, the surgical team failed to examine A in person when consulted which was unreasonable. Overall, we considered that the care and treatment provided to A was unreasonable and upheld this part of C's complaint.

In relation to nursing care, we found that the care and treatment provided to A was reasonable. We also found that A's death certificate was not completed incorrectly. Therefore, we did not uphold these part's of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to take an accurate medical history on admission, there was a missed opportunity for the vascular team to identify the correct diagnosis during their review of A, the failure to consider a diagnosis of aorto-enteric fistula earlier, and particularly, once the CT scan findings were available, and the failure of the surgery team to review A in-person. 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:

- Accurate medical history should be established by clinicians and investigations, including CT scans, that are carried out should be critically reviewed when considering diagnosis alongside the history. Medical records should be viewed to establish/confirm the correct medical history.
- When asked, the surgical team should fully review the presentation and history of the patient. Where necessary the patient should be seen in-person.
- When a specialist review is requested such as vascular, the specialist team should fully review the presentation and history of the patient.

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.