

Case: 201004517, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: health

Subject: clinical treatment / diagnosis

Outcome: some upheld, recommendations

Summary

Mrs C made a number of complaints to the board. Her husband, Mr C, was referred by his GP to hospital in March 2010 with swallowing difficulties. Initial investigations proved negative and further tests were planned. However, in May 2010 Mr C attended as an emergency and it was established that he had stomach cancer. Mr C died in June 2010 at home.

Mrs C complained about a delay in diagnosis and that there was a lack of communication from staff about Mr C's condition. The investigation revealed that although the diagnosis may have been established slightly sooner, it would not have affected the final outcome. However, it would have allowed Mr C and his family more time to come to terms with the situation. The investigation also upheld complaints that there were failings in communication and that the record-keeping was inadequate. We did not uphold a complaint that the board handled the complaint inadequately.

Recommendations

We recommended that the board:

- share this letter with staff to note our adviser's comments with specific reference to referring Mr C for an urgent endoscopy following the results of the barium swallow rather than discuss the result at a planned appointment;
- remind staff of their responsibilities to communicate in an effective manner with patients and their relatives and to accurately record what has been discussed; and
- remind staff to obtain informed consent from patients prior to carrying out medical procedures.