SPSO decision report

Case: **201805039, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment his late brother (Mr A) received at Queen Elizabeth University Hospital (QEUH). Mr A had a number of complex medical conditions; he had previously undergone liver transplantation and suffered a brain aneurysm. Mr A was admitted to QEUH for treatment associated with an unusual resistant form of cytomegalovirus (CMV, a virus). Mr A's health deteriorated during his admission and he died in hospital.

Mr C complained that the board failed to provide Mr A with reasonable clinical care and treatment. Mr C also raised concerns that there was a lack of reasonable communication with him and his family about Mr A's care and treatment.

We took independent advice from a consultant gastroenterologist (a physician who specialises in the diagnosis and treatment of disorders of the stomach and intestines); a consultant in critical care and anaesthesia with experience in transplant services and a senior nurse.

We found that there were aspects of Mr A's care and treatment that were reasonable. In particular, in relation to the management of Mr A's blood pressure and the fall in his platelets. When Mr A's condition deteriorated, there was no unreasonable delay in escalating him to the intensive care unit (ICU). In relation to the staff caring for Mr A, there was clear evidence of regular reviews and consultation and liaison between a large number of different specialists at QEUH and the transplant unit.

However, we identified the following failings in Mr A's clinical care and treatment:

For a period of time it was not noticed that there was an unintentional co-adminstration of two medications. While, on balance, any impact was limited and was not a significant contribution to Mr A's eventual outcome, this should not have occurred and was an omission in care. This was acknowledged by the board and appropriate action was taken.

We found that there was a lack of recording of Mr A's titres (level of virus). In addition, insufficient consideration was given to carrying out further investigations in order to confirm a diagnosis of Mr A having posterior reversible encephalopathy syndrome (PRES, a rare condition in which parts of the brain are affected by swelling) rather than CMV encephalitis as a possible alternative diagnosis.

Mr A had infected CMV that was known to be resistant to valganciclovir (antiviral medication) and the decision to restart Mr A on this medication was unreasonable. As this treatment was ineffectual, an alternative treatment should have been considered. Whilst it was wrong to use valganciclovir, on balance, taking account of the evidence any impact was limited and was not a significant contribution to Mr A's eventual outcome.

We found that communication with Mr A's family was reasonable while he was in ICU. However, prior to this

communication with Mr A's family could have been better and their concerns about aspects of his care and treatment did not appear to have been reasonably addressed.

Mr C further complained that the board's investigation of and response to his complaint was inadequate. The board acknowledged that their complaint response letter was not issued within 20 working days in terms of the relevant guidance. Given the complexity of the complaint, we considered that the delay in providing a response was reasonable in the circumstances. However, we identified an error in the board's calculation of when the 20 day working period for providing a response to Mr C's complaint started. Following the issue of the board's response to the complaint, Mr C had contacted the board making further comment. We considered that the board should have informed Mr C when he could reasonably have expected to receive a response to his further correspondence and if there was going to be a delay in providing this. However, this had not happened.

We upheld all of Mr C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and his family that insufficient consideration was given to carrying out further investigations in order to confirm a diagnosis of PRES; about the decision to restart valganciclovir and not to have considered an alternative treatment for resistant CMV; for the failure to record Mr A's titres; for the lack of reasonable communication with Mr C and his family about Mr A's care and treatment; and for the failings identified in complaint handling. 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:

- Patients should receive appropriate investigation prior to confirming a diagnosis of PRES. Decisions about medication should be reached after careful consideration of the effectiveness of the medication and potential side effects. There should be appropriate recording and monitoring of a patient's condition and this should be documented.
- Communicating significant news, especially bad news, to a patient and/or their family should be carried out in a clear and sensitive manner and without any unreasonable delay.

In relation to complaints handling, we recommended:

- Complaint responses should be accurate and in accordance with the board's Complaints Handling Procedure. The board should aim, whenever possible, to inform a complainant about when they should expect to receive a response to their communication and if there is going to be a delay in providing this.

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.