SPSO decision report

Case: **202107863, 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 of their late partner (A) during multiple admissions to hospital. C raised concerns that a coronary angiogram (a scan to check for blockages in the blood vessels) was unreasonably delayed, which in turn meant necessary vascular surgery could not take place. C complained about a lack of cohesion between vascular, cardiology and renal teams, and a lack of communication with the family.

We took independent clinical advice from a cardiology adviser and a vascular adviser. We found that there was a lack of cohesion and coordination in the management of A's treatment plan. We considered that multidisciplinary meetings should have taken place to agree a treatment plan, and provide the cohesion that was lacking in the approach to A's treatment. Overall, however, we found that the clinical decisions made by each team were reasonable and reflected A's clinical condition at the time. We found nothing to suggest that the lack of cohesion impacted directly on the treatment A received or the eventual outcome for A. In particular, we found that there were good reasons not to proceed with the coronary angiogram, and that it was unlikely any vascular intervention could have been provided due to A's competing illnesses. On balance, therefore, we did not uphold the complaint that A's clinical care and treatment was unreasonable.

However, we upheld the complaint about the communication with A and their family. The board had already apologised for the poor communication and acknowledged that the multidisciplinary team did not keep the family as informed as they could have. Notwithstanding this, the board considered that A had capacity to make decisions regarding their own care and treatment. However, this assertion did not appear to have been based on any formal assessment. We found that there was evidence only once in the records of a capacity assessment having been undertaken. We found this concerning, particularly as C had raised concerns that A had become confused as a result of their illness and strong pain medication. We also found that there was a failure to complete existing documentation to record A's communication preference, which was suggestive of a systemic failure rather than an issue that affected only A. Overall, we found that the communication with A and the family was very poor. A had a complex illness with a number of competing factors which affected the types and timings of treatments that were available. We concluded that clearer communication with the family, and between healthcare professionals, may have avoided a lot of the distress and anxiety the family experienced.

Recommendations

What we asked the organisation to do in this case:

- That the board apologise to C for the issues highlighted. 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:

- That the board conduct an audit into the hospital staff's compliance with their obligation to complete the existing documentation and take steps to ensure the documentation is being used effectively to ensure

patient-centred care.

- That the board provide us with evidence of the steps that they have taken to ensure multidisciplinary team meetings take place to discuss and plan treatments for patients with complex medical conditions.
- That the board share this decision notice with the teams that were involved in A's care and treatment with a view to identifying any points of learning.

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.