SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201508152, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C's father (Mr A) was treated with radiotherapy for cancer of the tongue. Following his treatment, Mr A was cared for in the community with regular reviews at a joint cancer clinic and input from dieticians in another health board. He also received speech and language therapy (SALT) as part of the cancer clinic for about six months, and was then referred back to the other board for ongoing SALT care.

In the 18 months following his treatment, Mr A had increasing difficulty swallowing and suffered from recurrent mouth ulcers and pain. He also had several short hospital admissions with bleeding from the mouth. He was subsequently admitted to hospital (in another health board) in June 2014 with weight loss, decreased ability to swallow and stridor (noisy breathing caused by a narrowed or obstructed airway). He underwent endo-tracheal intubation (insertion of a tube to maintain an open airway to the lungs) and was transferred to St John's Hospital (for intensive care and ear, nose and throat (ENT) investigations), and then to the Royal Infirmary of Edinburgh (for gastrointestinal investigations). Mr A suffered a major haemorrhage (bleeding) from the throat and died in hospital.

Mrs C complained about Mr A's care during this period, and raised concerns that clinicians failed to adequately respond to Mr A's mouth pain, malnutrition and weight loss, as well as infections in his mouth. Mrs C also raised concerns about care and communication during the hospital admissions in June 2014.

After taking independent advice from an oncologist, a consultant in general medicine, an ENT surgeon and a SALT therapist, we upheld three of Mrs C's four complaints. We found that, although Mr A had regular reviews and involvement of appropriate clinicians in his care, there was a lack of integration and cohesion in the team's approach, which meant that Mr A's symptoms were not adequately addressed. We also found failings in relation to communication during Mr A's final admissions, although we found that the medical care during these admissions was reasonable.

Recommendations

We recommended that the board:

- feed back our findings to the staff involved for reflection and learning;
- use Mr A's experience as a learning tool to promote patient-centred care and provide us with evidence of this;
- review their processes for ensuring joined-up post-treatment care for patients with head and neck cancer;
- apologise to Mrs C and her family for the failings identified in our investigation;
- feed back our findings on communication to the nursing and medical staff involved for reflection and learning; and
- demonstrate that the incident of the missing Royal Infirmary of Edinburgh records has been investigated and reported, and provide details of any resulting action.