SPSO decision report

Case: **201805983, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained on behalf of Mr B about the care and treatment provided to Mr B's late wife (Mrs A). Mrs A had an underlying heart condition and her medication had to be carefully balanced to avoid kidney damage. Mrs A saw her GP about problems with bowel function and her deteriorating general condition. The GP referred her to the colorectal (relating to or affecting the colon and rectum) clinic. Blood tests taken around the same time showed her kidneys were deteriorating and she was referred for an urgent renal (relating to the kidneys) appointment.

During her colorectal consultation, Mrs A was offered various investigations but a CT scan (a scan that uses x-rays and a computer to create detailed images of the inside of the body) and colonoscopy (examination of the bowel with a camera on a flexible tube) both involved some kidney risk, so she wished to wait for her renal appointment before making a decision. She received a renal appointment four months after her GP appointment and was admitted the following day for further tests including a CT scan performed without contrast (contract material is a dye used to help highlight areas of the body being examined) as this was safer for her kidneys. Around a month after admission for tests, stage 4 cancer was found in bowel, stomach and lungs, which Mrs A was advised had been present for months. A decision had been taken to downgrade Mrs A's renal referral without seeing her, and without informing her GP. Mrs C complained that this decision was unreasonable.

The board confirmed that Mrs A's urgent renal referral was downgraded without her being seen, based on the likelihood that her renal dysfunction was a composite of her heart disease and medication. As her blood test results were relatively stable the board had considered there was no need for an urgent referral. The board apologised that the GP had not been informed. We took independent advice from a nephrology (the branch of medicine that deals with the physiology and diseased of the kidney) adviser. We found the downgrading of the referral to be reasonable under the circumstances. Therefore, we did not uphold this aspect of Mrs C's complaint.

Mrs C also complained that the board unreasonably failed to offer Mrs A a CT scan without contrast at an earlier stage. We took independent advice from a colorectal adviser. We found that although this could have been offered, the consultant responsible reasonably balanced consideration of establishing a diagnosis and of investigating only should her symptoms recur, given the severity of her underlying disease. Therefore, we did not uphold this aspect of Mrs C's complaint.

Finally, Mrs C complained that the communication between specialisms involved in Mrs A's care and treatment was unreasonable. We found that the decision to downgrade the renal referral was not conveyed to Mrs A's GP or her cardiac consultant and that Mrs A's cardiac consultant had delayed in informing her about the availability of the advanced heart failure specialist nurse. We also found that communication between medical staff had not been copied to the Mrs A, noting that if this had done, the perceived lack of communication could have been avoided. Overall, we found that the board's systems were reasonable, in that all Mrs A's records were available to those involved in her care. However, we upheld this aspect of Mrs C's complaint on the basis that the board had accepted errors and delays.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr B for the failings in communication, with a recognition of the cumulative impact of these failings on Mrs A's treatment experience. The apology should acknowledge the impact of these failings on Mrs A and her family. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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.