SPSO decision report

Case:	201810045, Tayside NHS Board
Sector:	Health
Subject:	clinical treatment / diagnosis
Decision:	upheld, recommendations

Summary

C brought a complaint to us about the care and treatment given to their late spouse (A) who had a diagnoses of myeloma (a type of cancer arising from plasma cells found in the bone marrow). C told us the reasons they considered the board had provided A with unreasonable clinical care and treatment were that there had been a delay in the diagnosis and treatment of endocarditis (an infection of the endocardium, which is the inner lining of the heart chambers and heart valves); there had been a lack of communication about A's state of health, and their prognosis was not communicated until three days before they died. Finally, A had been discharged home although they were very ill.

C also raised a number of concerns about the nursing care and treatment given to A, in particular that there had been a lack of communication and that the level of general nursing care and treatment was unreasonable.

We took independent advice from a consultant in cardiology, a consultant in acute medicine, a haematology consultant and from a nurse. We found that overall the cardiology care and treatment was reasonable, also that the care and treatment from an acute medicine perspective was appropriate. We also found that the haematology care given to A was reasonable and in line with the British Society of Haematology and UK Myeloma forum 'Guidelines for screening and management of late and long-term consequences of myeloma and its treatment'. However, we considered that there had been poor communication with A's family, in particular around the significant risk associated with their illness and the risk that their condition would ultimately prove to be untreatable. The board had accepted there were gaps in communication and detailed the action taken to improve communication with the patient and their family. As such we upheld the complaint.

In relation to the nursing care and treatment given to A, we found that there was clear documentation of care needs, ongoing evaluation and assessment, with escalation to medical staff when required. The nursing care in relation to the administration of medication overall was also reasonable. However, we found that communication was unreasonable in relation to care. The board accepted failings in relation to communication and detailed the action to be taken.

Given the failings in relation to communication which forms part of ensuring patient centred care, on balance, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

• Apologise to C and the family for the failings identified in this case. The apology should meet the standards set out in the SPSO guidelines on apology available at 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.

