SPSO decision report

Case: **202107450, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A). Scans revealed findings that were suggestive of bladder cancer. Over a number of further admissions, A received treatment to resect (remove) a bladder tumour, fit and remove catheters, treat infection and generally manage A's condition. Eventually, it was decided that A's condition should be managed palliatively, and A was discharged home.

C complained that the medical and nursing care and treatment A received from the board was unreasonable and that the communication with A and their family was unreasonable.

The board said that A was not medically or psychologically fit for further management of their condition and they were not a candidate for chemotherapy or radiotherapy. A was referred to palliative care once it was identified that they were also not a candidate for surgery. The board said A chose not to share their diagnosis for a number of weeks and were unwilling for discussions to take place with their family.

We took independent clinical advice from a consultant urologist (specialists in he male and female urinary tract, and the male reproductive organs) and a registered nurse. We found that the surgical care was of a reasonable standard and that the board adopted a holistic approach. However there was a failure to detect the bladder tumour when it was initially suspected and a failure to follow up with A about their nephrostomy (a thin tube inserted through the skin directly into the kidney to allow urine to drain into an external drainage bag) and JJ stents (a thin flexible tube placed to help urine flow). We also found that there was a delay in organising an inpatient CT scan, failures in relation to discharge planning and a failure to care for A's skin and pressure damage.

In relation to communication, we found that the board failed to tell A that there was a suspicion of bladder cancer at an appropriate time and it was unreasonable for the board not to communicate with A's family when arranging discharge.

We considered that the board failed to provide reasonable care and treatment to A and failed to communicate reasonably with A. Therefore, we upheld these parts of C's complaint.

C complained that the board failed to handle their complaint reasonably. We found that the board's investigation and response contained a number of factual inaccuracies, particularly with the accuracy of dates and order of events, and that important information was omitted from the response. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide reasonable care and treatment to A, failing to communicate

reasonably with A and their family, and failing to provide a reasonable response to C's complaints. 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:

- Discharge planning should take into account the patient's ability and motivation to complete required self-care tasks such as catheter and nephrostomy care. Patients should be issued with a copy of the discharge letter where appropriate. When a patient does not live independently family members should be informed of their discharge to ensure there is appropriate care in place.
- There should be nurse specialist support for patients with urological cancers. Nurse specialists should contact the patient within a reasonable timescale. Patients should be assessed to ensure suitability before phone consultations are carried out. Patients should be supported, where possible, when bad news is being communicated to them. Relevant updates should be given to a patient in a timely manner.
- There should be adequate trainee supervision during surgical procedures in keeping with the trainee's experience. Patients should be informed of investigation findings if they are suspicious of a cancer diagnosis. When there is a suspicion of cancer further investigations should be carried out with due diligence. Relevant findings should be discussed with the patient and recorded in the medical notes.
- A pathway should be in place to ensure that patients with nephrostomies and/or JJ-stent are followed-up in line with best practice time frames.
- Inpatient scans should be carried out within a reasonable time frame.
- Wound charts should be in place for pressure wounds and there should be subsequent weekly assessments. Care rounding should be delivered to the frequency required to prevent pressure damage. Patients should be appropriately moved position to avoid worsening pressure damage.

In relation to complaints handling, we recommended:

- Complaint responses should be factually accurate. Details such as dates and the order of events should be supported by what is recorded in the medical records, and these should be checked for accuracy before the response is issued. Complaint responses should be completed in line with the NHS Model Complaints Handling Procedure.

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.