SPSO decision report

Case: **202209212, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (B) about the care and treatment provided to B's spouse (A). A experienced urological symptoms including blood in their urine and a number of infections. After a number of investigations, A was diagnosed with bladder cancer which had spread to their prostate. A died a short time later.

C raised a number of complaints and we agreed to investigate four main concerns: that the board failed to provide a reasonable standard of urological treatment following insertion of a catheter, the delay in diagnosing A's cancer; poor communication with B and A, and A's poorly managed discharge from hospital.

We took independent advice from a consultant urologist.

C raised concerns that A's catheter had to be refitted a number of times, which was difficult to do and caused A pain and discomfort. The board explained that a catheter is commonly fitted after surgery and a permanent catheter was fitted due to A's past urology history and difficulty in emptying their bladder. We found that whilst it was reasonable to insert a catheter, the reasoning behind the decision was poorly documented and that as A required a number of emergency admissions for catheter related issues, the board should have considered an emergency cystoscopy (a procedure that uses a tube to examine the bladder and the urethra) and TURP (transurethral resection of the prostate) and they failed to do this.

Whilst it is agreed that A's case was complex and a number of investigations were required, we found that there was a delay in arranging a diagnostic cystoscopy following an emergency admission, a breach of the waiting time target for cancer referrals and a failure to recognise the significance of paraaortic lymphadenopathy (lymph nodes of an abnormal size) which contributed to the delay in diagnosis of A's cancer. We accepted that had this delay been avoided, A's outcome likely would have been the same, although their quality of life would have been improved.

With regards to communication, we did not identify any issue with the volume or frequency of communication with A. However we concluded that important medical details were overlooked or not explained clearly, such as A's urological diagnosis and overall management plans.

Our investigation also concluded that whilst it was appropriate to discharge A home due to their condition being manageable with pain relief and antibiotics, there was a failure to ensure adequate pain relief would be available to A.

We upheld all four complaints and made appropriate recommendations for learning and improvement.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the issues highlighted in this decision. 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 A's case be reviewed at the local Morbidity & Mortality meeting with a view to identifying opportunities that were missed to progress A's diagnosis and ways of ensuring similar delays do not affect future patients.
- That the board review the record keeping in A's case and take steps to ensure their junior doctors and trainees are receiving adequate training in good medical record keeping and that senior clinicians are reminded of their responsibility to maintain sufficiently detailed records of discussions with patients and relatives.
- That the senior staff involved in A's care be asked to reflect on the way that bad news was delivered on this occasion, and in general, with a view to ensuring they do so in as inclusive and compassionate a way as possible and with reference to the MDU guidance on breaking bad news.

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.