# SPSO decision report

**Case:** **202303636, Tayside NHS Board**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** upheld, recommendations

## Summary

C complained on behalf of their parent (A) who passed away in hospital. During the admission, A was diagnosed with B cell lymphoma (a type of blood cancer) and received palliative radiotherapy treatment.

C complained that A's pain medication was incorrectly managed as they experienced both delirium and extreme pain, that A's nutrition and fluid intake was incorrectly managed as A became dehydrated and lost weight, that A was left in a general ward rather than being moved to a cancer ward and that A was not offered chemotherapy. C complained that there had been a lack of communication regarding A's palliative treatment plan, A's deterioration and death.

The board advised that A's pain medication had been appropriately reviewed and adjusted. C's fluid intake was difficult to manage but there was no indication for nasal gastric feeding. They apologised that there were gaps in the records in relation to fundamentals of nursing care, including nutrition, fluids and skin care and that nurses had since undertaken training. They noted that A was deemed too unwell to tolerate chemotherapy or a move and they stated that a number of discussions took place with the family to explain A's changing condition.

We took independent advice from a consultant geriatrician, a registered nurse and a consultant haematologist. We found that A's pain had been reasonably controlled and the decision not to offer chemotherapy was reasonable. However, medical staff should have considered nutrition support earlier and nursing care had been unreasonable in relation to nutrition, fluids and skin care. Communication from doctors and nurses on the ward was reasonable, but there had not been any communication from a specialist about A's cancer prognosis and palliative radiotherapy treatment. Therefore, we upheld all aspects of this complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C that no specialist explained the lymphoma diagnosis and treatment plan to the family. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C that nursing care and recording was unreasonable, in regards to pain assessment, nutrition, hydration and skin care. Apologise to C that medical staff did not offer nutritional support at an earlier stage. 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:

- Person centred care plans should be recorded and followed for each patient. If radiotherapy patients are treated in general wards, nursing staff in those wards should be trained on how to manage radiotherapy skin damage. Nutritional support should be considered for vulnerable patients and medical staff should be

aware of alternative methods of weight loss assessment in patients with oedema.

- A specialist explains the cancer diagnosis and treatment plans to the patient and family.

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.