SPSO decision report

Case: **202304348, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their spouse (A). A had a history or recurring urinary tract infections (UTI's) and was self-catheterising. The board gave A an indwelling (long-term) catheter to be changed every three months. Over the next several months, A attended A&E five times before being admitted and diagnosed with bladder cancer. C complained about the lack of arrangements to change A's indwelling catheter, that requests for appointments were ignored and that A was only admitted after multiple visits to A&E.

We took independent advice from a consultant urologist (specialist in the male and female urinary tract, and the male reproductive organs), consultant in emergency medicine and a medical director specialising in palliative care. We found that, as the indwelling catheter was a trial, the board should have followed up with A on their progress. There was also unreasonable delays in A being seen by urology and in being advised of their cancer diagnosis. While it was reasonable that A was not admitted by A&E for examination sooner, the board acknowledged that there was a missed opportunity. Therefore, we upheld this part of C's complaint.

C also complained that A's cancer diagnosis, discharge and care arrangements were not clearly explained. We found that the board made reasonable efforts to explain the cancer diagnosis to C and A. However, they did not reasonably communicate how they might manage once A was discharged home, and about the challenges associated with A reaching end of life. Therefore we upheld this part of C's complaint.

In relation to complaint handling, we found that the information provided to both C and this office was inaccurate in places and incomplete. Therefore, we made a recommendation to improve the board's complaint handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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 .

What we said should change to put things right in future:

- When a relevant adverse event occurs, the board should carry out a Significant Adverse Event Review (SAER) to investigate the cause and identify any potential learning.
- Patients should receive timely review, follow-up appointments and information based on their clinical needs and presentation and in accordance with relevant guidelines. A's case should 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. The Board should consider whether this case could be used as an opportunity to reflect and improve the interface between the urology and emergency departments in order to minimise the risk of a similar case occurring again.

- Discharge planning should be person-centred and holistic and clear to patients, families and community services. In particular, the palliative care team may support complex discharges but it is the ward team who are best placed to support the patient's discharge. Teams should not just focus on their area of interest e.g. urology but on caring for the whole person. Patients with palliative care needs should be supported within their limited function to live well. Expectation of rehab should be realistic. Staff should explore what is realistic, what the patient and their families' concerns are and also be brave and explore where there are gaps in the system of support, what the best possible mitigation is. There should be thorough documentation of this. Spiritual / other support should be available. They are non-denominational / nonfaith and provide support to patients and families. Learning sessions should occur around recognising a palliative deterioration or the acute deterioration covered by NEWS. Recognising someone heading to the end-of-life phase is essential, as are developing communication skills to support staff to engage with patients and families.

In relation to complaints handling, we recommended:

- Information provided to SPSO and the complainant should be accurate and complete. All relevant records in relation to an SPSO investigation should be provided from the outset of our enquiries.

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.