SPSO decision report

Case: **201104504, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained that delays in the investigation and treatment of her late husband's cancer hastened his death. She also complained about a lack of nursing and personal care provided to him, including pain relief; inappropriate discussions about resuscitation; a shortage of beds in the specialist respiratory ward and the hospice; delays in giving her access to her late husband's medical records; and that the board delayed in dealing with her complaints.

Our investigation found that Mr C had been investigated for pain, stiffness and swelling in his legs and ankles, which was attributed to a rheumatic condition. However, as this condition can also affect the lungs, a chest x-ray was taken in January 2011. The x-ray was reported to be normal and Mr C's treatment and monitoring of the rheumatic condition continued. In February 2011 Mr C's condition had deteriorated, and he had lost weight. He returned to the rheumatology clinic for further investigations. Various investigations including computer tomography (CT – a special investigative scan) and positron emission tomography (PET – a special investigative scan) were undertaken and Mr C was diagnosed with lung cancer in March 2011. The cancer was an aggressive one and by the time of diagnosis it had already spread and was considered to be inoperable. Despite treatment, including chemotherapy, Mr C died in June 2011.

We took independent advice from three of our medical advisers - a respiratory physician (lung specialist), an oncologist (cancer specialist) and a senior nurse. The respiratory physician was critical that the January x-ray was reported as normal as there was what he felt to be 'unequivocal', if fairly subtle, indications of abnormality on the x-ray. However, he and the oncologist agreed that even had this x-ray been correctly reported and a referral to the chest clinic made in January 2011 the outcome and duration of Mr C's life would have been the same. They also agreed that Mr C's management was otherwise appropriate and timely. The nursing adviser was, however, critical of the lack of assessment, monitoring and review of Mr C's pain; the standard of the notes; and the lack of personal care, including washing, provided to him.

Our investigation identified several areas of concern and we upheld five of the six complaints. The only complaint we did not uphold was that about the lack of beds in the respiratory ward and hospice. We found that the only reason Mr C was not transferred was because there was a particularly high demand for beds at that time. Mr C was transferred to the respiratory ward as soon as a bed was available, but died before a bed was available in the hospice.

Recommendations

We recommended that the board:

- issue a written apology;
- review a sample of x-ray reports to ensure that no others have been mis-reported;
- review the process of reporting on x-rays to ensure timely reporting;
- ensures that all relevant information is recorded on the multi-disciplinary team meeting forms;

- reviews the policy on ordering PET scans in line with SIGN (Scottish Intercollegiate Guidelines Network);
- review training on the discussion, decision making, review and recording of 'do not resuscitate' decisions;
- ensure that all nursing staff are aware of and implement national and local guidance on assessment, management and review of patients' pain;
- ensure that all nurses are aware of the need to provide regular and appropriate personal care where patients require assistance;
- ensure that all nurses are aware of and implement national guidance on record-keeping issued by the Royal College of Nursing; and
- report on the remedial action taken to prevent a recurrence of delays on access to copy medical notes.