SPSO decision report

Case: **201204456, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C's father (Mr A) suffered from lung cancer, and was being treated with palliative erlotnib therapy (a drug used to treat some types of cancer) by a consultant at Ninewells Hospital. Mr A became ill while on holiday with his family and was admitted to hospital. When the family returned home, Mr A was transferred to Ninewells as he was too ill to go home.

At a meeting with Mr A and his family, the consultant decided to discontinue the erlotnib therapy and focus on symptom control. Medical staff recommended that Mr A be transferred as an in-patient for palliative care, but Mr A and his family decided that he wished to be discharged home. A package of care was requested to support this, but Mr A passed away on the morning of his planned discharge.

Mr C complained to the board that they had failed to arrange a care package in time to enable Mr A to die at home, as he had wished. Mr C also raised several concerns about Mr A's care, record-keeping and communication with hospital staff. The board responded four months later. Staff from the board then met with Mr C and his mother, and agreed what they would do in response to the complaint. In response to Mr C's enquiries, the board wrote to him about the outcomes of these actions. However, Mr C remained dissatisfied with their response, and their handling of his complaint, and complained to us.

After taking independent advice from our medical and nursing advisers, we upheld some of Mr C's complaint. We found that the board had handled his complaint poorly, and had not complied with their own complaints handling procedure or NHS guidance. We also found evidence of poor communication and record-keeping. However, we did not find evidence that Mr A's medical and nursing care was unreasonable. We also found that hospital staff had taken reasonable and timely steps to try to help Mr A achieve his wish to die at home, although this did not happen.

Recommendations

We recommended that the board:

- issue a written apology to Mr C and his family for the record-keeping failings our investigation identified;
- provide us and Mr C with a copy of the quality improvement loop developed for addressing issues with documentation, and details of the Nursing and Midwifery Council code of conduct and accountability sessions arranged to reinforce the need for accurate record-keeping;
- raise our findings in relation to record-keeping with the doctor concerned, for reflection;
- review their complaint management procedure and practices to ensure they comply with the NHS 'Can I help you?' guidance in relation to responding to complaints within 20 days of receipt of the complaint (including where the complaint is received by phone) and informing complainants that they may approach the SPSO if the final response is not provided within 20 working days;
- review guidance and/or template letters for acknowledging and responding to complaints to ensure that all letters include an accurate date (including year), acknowledgement letters provide accurate information on

who will sign the final response, and letters for complaints which will exceed the 20 working day time-frame provide an updated time-frame and inform the complainant that they may now approach the SPSO; review processes for ensuring that they meet any commitments made to contact the complainant following the resolution of the complaint (for example, to advise when outcomes or agreed actions are completed); and

- remind complaints handling staff of the need to accurately record the date a complaint is received (including where the complaint is made by phone or in person), the requirement in the board's procedures for a deputy to be appointed where staff involved in a complaint will be absent, and the SPSO guidance on apologies - in particular that apologies should identify and acknowledge what mistake has been made, as well as the impact on the person being apologised to.