SPSO decision report

Case: **201302557, Grampian NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Outcome: some upheld, recommendations

Summary

Mrs C's stepfather (Mr A) was diagnosed with advanced bowel cancer in 2011 and had chemotherapy (a treatment where medicine is used to kill cancerous cells). In 2012, he was admitted to Aberdeen Royal Infirmary twice. Mrs C said that during the second admission a doctor told Mr A his chemotherapy had been positive but that he would not receive any more in view of problems with blood clots. Mrs C said that they later found out that it was stopped because his cancer had progressed. Mr A was admitted to hospital for a third and final time several weeks later. Mrs C said that staff failed to provide a discussed and implemented care plan about support throughout Mr A's illness and end of life care. She said that Mr A wanted to be with his wife (Mrs A) and receive end of life care at home, but was not consulted about his wishes or where he preferred to die. Mrs C said a doctor said that the aim was to get Mr A's pain under control and discharge him home. However, Mrs A received a phone call several days later telling her that he would be transferred to Peterhead Community Hospital under the care of his medical practice. Mrs C said that Mrs A was not told before the transfer that her husband was deteriorating significantly. He died six days later.

Mrs C said that clinical staff at Aberdeen Royal Infirmary failed to involve Mr A and his family in the transfer decision and failed to discuss the likely outcome for him, or the possibility that he could be cared for at home. In relation to her complaint about nursing staff at the community hospital, Mrs C said that they failed to provide a reasonable standard of care in terms of communication, personal care and dignity.

After taking independent advice from two of our advisers - a GP and a nurse - we found that staff failed to involve Mrs A and the GP in the decision to transfer Mr A to the community hospital. Given Mr A's condition, we were also concerned that he was not in a position to have an informed and reasoned discussion with medical staff about the transfer or to let them know his end of life care wishes. Although there was evidence that the likely outcome was discussed with Mr A and his family, there was no detailed record of Mr and Mrs A's understanding of this, as there should have been. Nor was there an anticipatory care plan which would have contained their wishes about where Mr A would prefer to die.

In relation to Mrs C's complaint about Mr A's personal care in the community hospital, we could not reconcile the differing accounts of what happened. Our nursing adviser said that the overall standard of care was reasonable, although in the absence of evidence we could not reach a judgement on Mr A's levels of hydration (fluid replacement). Having considered the medical records, we were satisfied that these clearly showed that the level of communication about Mr A's condition was reasonable. Similarly, we were satisfied that the care and support from district nurses was reasonable although there was no evidence that staff completed or referred to an end of life care plan. However, our nursing adviser said that a district nurse would not be expected to write an end of life care plan alone.

Recommendations

We recommended that the board:

- bring the failures our investigation identified to the attention of the relevant health care professionals involved in the transfer decision;
- provide evidence of how they intend to address the failings in relation to anticipatory care planning for end of life;
- bring the failures our investigation identified to the attention of the relevant health care professionals involved in discussions with Mr A and his family, and ensure they are raised as part of their annual appraisal; and
- provide the results of their review into their processes and procedures around communication and end of life care.