SPSO decision report

Case: **201406308, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment received by her late husband (Mr C) while he was a patient at Raigmore Hospital. Mr C underwent surgery to treat colon cancer but he continued to experience health problems and had a number of readmissions over the course of the following months. Around five months after surgery, investigations showed a recurrence of Mr C's cancer. He was admitted to a hospice for palliative care and died two months later. Mrs C raised concerns about the steps taken to investigate her husband's ongoing symptoms and pain following the surgery. She also complained about a lack of planned follow-up action, including the omission of a referral to oncology.

We obtained independent advice from a consultant colorectal and general surgeon, who considered that the investigations undertaken during Mr C's admissions were reasonable and consistent with applicable guidance. The adviser noted that it was unfortunate that the investigations did not detect the recurrence of Mr C's cancer earlier but did not consider that this was due to a failing on the part of the board. We accepted this advice and did not uphold this complaint.

In relation to the decision not to refer Mr C to oncology following his surgery, the board indicated that the multi-disciplinary team had not felt that he would be fit enough to undergo chemotherapy. They noted that this was discussed with Mr C at the time but this discussion was not recorded in the clinical records. They acknowledged that it might have been useful for Mr C and his family to have met an oncologist to discuss the risks and benefits of chemotherapy and they apologised that this was not arranged. While accepting that Mr C was unlikely to have been fit enough for chemotherapy within the relevant time period, the adviser agreed that the opportunity to speak to an oncologist should have been considered. The adviser was critical of the board's failure to record their discussion with Mr C and noted that this was not consistent with the General Medical Council (GMC)'s guidelines on record-keeping. In the circumstances, we upheld this complaint.

Recommendations

We recommended that the board:

- reflect on the record-keeping failure highlighted in this case and take steps to ensure staff adhere to the relevant GMC guidelines in this area.