SPSO decision report

Case: **201508182, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her late father (Mr A), who had bowel cancer. She complained that there was an unreasonable delay between a referral being made by Mr A's GP and his treatment starting at Ninewells Hospital. Ms C also complained that the care and treatment provided to Mr A in Ninewells Hospital was unreasonable. She raised further concerns that the standard of communication between the board and Mr A and his family was poor. Finally, Ms C complained that the board's handling of her complaint was unreasonable.

We took independent advice from a consultant gastroenterologist and a consultant colorectal surgeon. We found that there was an unreasonable delay between the referral by Mr A's GP and his treatment starting at the hospital. Mr A's GP had made a routine referral to the board's colorectal service and we found that this referral should have been reprioritised by the board as urgent because Mr A had high risk symptoms. In view of this, we upheld this aspect of Ms C's complaint.

Mr A had elective right hemicolectomy (removal of the right side of the large bowel through keyhole surgery). Four days after this, he returned to theatre for emergency surgery. Following this surgery Mr A was transferred to the intensive care unit (ICU), where he died the following day. We found that the surgery and the care Mr A received in the ICU had been reasonable. However, we found that there was an unreasonable delay in starting Mr A on antibiotics when his condition deteriorated in the ICU. We were also concerned that the frequency of consultant review following Mr A's surgery was not in line with published good surgical practice standards. We also found that the standard of record-keeping was unreasonable, particularly as there were gaps in the medical records. In light of this, we upheld this aspect of Ms C's complaint.

We found that the communication with Ms C, Mr A and the wider family about Mr A's care and treatment had been unreasonable. We further found that the consent for the initial surgery was not obtained in line with guidance from the Royal College of Surgeons. As such, we upheld Ms C's complaint.

Finally, the board accepted that the handling of Ms C's complaint had been unreasonable and said that they had taken action to improve their complaints handling. In view of the failings identified, we upheld this aspect of Ms C's complaint, but did not make any recommendations about this as the board had already taken action.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for:
- the unreasonable delay between the referral to the board and the commencement of treatment
- the unreasonable care and treatment provided to Mr A
- the unreasonable communication and poor complaints handling.

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

- Referrals to the colorectal service from GPs should be appropriately validated to ensure that patients with high risk symptoms are prioritised. In order to facilitate this, the referral form for GP referrals to the colorectal service should ensure the proper documentation of details of symptoms, such as the extent of weight loss and anaemia.
- Appropriate action should be taken in the event of deterioration of a patient, especially in the event of a rise in early warning signs. Antibiotics should be administered in line with the board's observation chart.
- In-patients should be reviewed by a consultant surgeon (or equivalent), in line with the published good surgical practice standards.
- Surgeons should obtain the patient's consent in the pre-operative clinics, as per guidance from the Royal College of Surgeons. Patients should be provided with a copy of the consent form for reference and reflection at that time.
- Patients and/or their relatives should be kept fully informed after critical illness events.
- Medical staff should maintain reasonable medical records, in line with General Medical Council guidance.

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.