SPSO decision report

Case: **201508831, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C brought this complaint to us on behalf of her late grandfather (Mr A) in relation to the care and treatment he received from the board during investigations into urology symptoms, and subsequently, during an admission to the Jubilee Hospital.

Mr A was referred to urology in 2013 with symptoms indicating potential prostate cancer though treatment was not considered necessary. He was admitted to hospital following the identification of suspected metastatic cancer and a fall at home. He was cared for in a GP-led ward and received palliative treatment for his cancer symptoms. During his time in hospital he missed a consultant appointment because he was not informed of it. While the urology consultant was in contact with the GPs involved in Mr A's care, Mr A did not see a consultant after his diagnosis with metastatic disease until his death around four months later.

During our investigation of this complaint, we obtained independent advice from a urology adviser and a GP adviser. The urology adviser did not raise any concerns about the care and treatment Mr A received in relation to his prostate cancer. They noted that the timescales for Mr A's clinical review were not appropriate but that these timescales were overtaken by events. The adviser noted that the urology consultant had written to the GP on several occasions setting out his opinion of Mr A's condition and treatment decisions, though it was not recorded as to whether this had been explained to Mr A. Once he was in hospital, Mr A's care and treatment had been discussed at case conferences which included family members. When Mr A was first admitted to hospital, doctors completed a form to instruct that he should not be resuscitated in the event of a heart attack (a DNACPR form). This form was subsequently overturned following discussions with Mr A's family. This was noted on his medical records. Though Ms C said she saw Mr A's name on a list on the ward, there was no evidence of inaccurate records held by the board.

When Mr A was discharged to a nursing home, the family thought he was going to have rehabilitation so he could return home. Records passed between the board and the nursing home indicated he was being transferred for management of cancer symptoms. The GP adviser explained that Mr A was receiving palliative care, and it was possible that if his condition had stabilised he would have been able to return home. His condition deteriorated more rapidly than had been expected, and this could not have been foreseen. We accepted the advice provided by the advisers in relation to Mr A's care and treatment.

Ms C also raised concerns about the way her complaint was handled. She said that her grandmother (Mrs A) was contacted directly to gain consent, and that this was not appropriate. She also raised concerns that the board used the wrong name for Mrs A and that they did not provide a response within the appropriate timescales. We noted these issues and considered that the board failed to follow their complaints handling procedure.

Recommendations

We recommended that the board:

- feed back findings to the staff involved for reflection and learning;
- apologise to the family for the failings identified in our investigation;
- review their processes to ensure that complainants are contacted when consent is needed from a patient or next of kin; and
- review their processes to ensure that, where an investigation cannot be completed within 20 days, they contact the complainant to explain this.