SPSO decision report

Case: **201605262, Orkney NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mrs A). Mrs A was referred by her GP to hospital as she had an umbilical hernia. She had tests involving her chest, abdomen and pelvis which led to a suspicion of cancer, and a letter was sent to her GP advising that at the same time as her hernia was repaired, a biopsy would be taken. After these procedures, Mrs A was advised that it was likely that she had cancer. She was reviewed at a subsequent appointment where it was confirmed that she had advanced malignant disease.

Ms C complained about the way in which Mrs A had been told about her diagnosis and that she had not been given full information about the surgical procedures she was to undergo. She also said that the board had delayed in reaching a diagnosis and delayed in responding after Ms C made these complaints to them.

We found that Mrs A had been alone when her diagnosis was given to her and that no effort had been made to try to contact her husband before she was given bad news. We found little evidence that the procedures and the risks had been fully explained to Mrs A, despite the fact that she had signed the consent form as having understood. We upheld these aspects of the complaint. Although Mrs A felt that there had been a delay in diagnosing her, we found no evidence of this. She was seen within a month of referral, and tests were carried out in a timely way. We did not uphold this aspect of the complaint. However, we did find that when the board came to consider Ms C's complaints, they took too long, so we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should send Mrs A a formal letter apologising for failing to attempt to involve her husband or another supporter when she was given bad news.
- The board should send Mrs A a formal letter apologising for failing to discuss the risks of surgery with her.
- The board should send Mrs A a formal letter apologising for the delays in responding to her complaint.

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

- The board should ensure as far as possible that when patients are receiving bad news, they are personally supported by a friend or family member.
- The board should ensure that prior to elective surgery, a full explanation is given to the patient including information about the risks entailed. This conversation should be documented.

In relation to complaints handling, we recommended:

- The board should complaints should be responded to within the stated timeframes. Where this is not possible, the complainant should be updated.

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.