SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201701958, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A) at Victoria Hospital. Mr A attended the emergency department on two occasions as he was experiencing blood in his urine and was having difficulty passing urine. Following a urology (the area of medicine which specialises in the urinary tract and the male reproductive system) referral and investigation, Mr A was diagnosed with bladder cancer. Mrs C complained that that the care provided to Mr A in the emergency department was unreasonable, that there had been unreasonable delays in his subsequent care which meant his treatment options were limited and that the nursing care provided during later admission was unreasonable.

We took independent advice from an emergency medicine consultant, a consultant urologist and a nurse. We found that the care Mr A received in the emergency department was reasonable and we did not uphold this aspect of Mrs C's complaint. In relation to the delays, we found that there had been an unreasonable delay in providing Mr A with appropriate information about the plan for his out-patient care. We upheld this aspect of Mrs C complaint; however, we found that Mr A's prognosis was unaffected by this failure. Finally, we considered that there had been inadequate care planning for Mr A. The nursing adviser was unable to form a reasonable picture of Mr A's needs from the records provided which was unreasonable. We noted that the board had already acknowledged failings in connection with the nursing care. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for the delay in providing appropriate information on the plan for out-patient investigation of his symptoms. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Appropriate care should be provided and this should be clearly evidenced in the nursing notes.
- Staff caring for patients like Mr A should have access to detailed information needed to ensure care is individualised and tailored to their needs.

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.