SPSO decision report

Case: **201803892, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained that the care and treatment he received at Dumfries and Galloway Royal Infirmary was unreasonable. Mr C has metastatic (cancer that spreads to other parts of the body) prostate cancer and chronic kidney disease. His complaint primarily concerned his nephrostomies (catheters inserted through the skin and into the kidneys to drain urine). He had experienced problems with catheterisations, and had infections and leaking. He complained that the reasons for his treatment had not been explained to him, especially in relation to his elective transurethral resection of the prostate procedure (a surgical procedure that involves cutting away a section of the prostate) and nephrostomies.

We took independent advice from a consultant urological surgeon (a clinician who treats disorders of the urinary tract). We considered that Mr C's initial treatment was reasonable. After catheterisation failed to improve his kidney function, nephrostomies were inserted on both sides. However, we were critical of the follow-up to the nephrostomies, particularly as Mr C was not offered direct access back to the clinical team at the hospital should any problems arise. We considered this especially important in light of subsequent frequent blockages which resulted in an A&E attendance. Taking into account Mr C's particular range of symptoms, we also questioned the decision to operate on Mr C's prostate to relieve obstruction, which carried a low chance of him being able to empty his bladder naturally. Therefore, we upheld this aspect of Mr C's complaint.

Mr C also complained that the board's communication was unreasonable. We found that there were shortcomings in record-keeping and could not find evidence that the board had provided Mr C with clear information regarding the prostate surgery and nephrostomies, or the impact that this would have on Mr C long-term. We noted that Mr C did not appear to have been given written information about who to contact in case of difficulties or concerns. Therefore, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failings in treatment, with a recognition of the impact on Mr C's quality of life and apologise for the failings in communication. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- The board should provide Mr C with a point of contact, to ensure he is seen promptly by a clinician with understanding of his condition in the event he experiences further problems with his nephrostomy.

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

- If possible, the terms of this decision letter should be shared with those clinicians who were involved in Mr C's care, in a supportive manner, with evidence they have reflected on this. An anonymised version of this letter should also be shared with urology clinicians employed by the board to carry out treatment of this nature, with a reminder of the importance of good record-keeping. The board should consider the

presence of urology nurses during consultations, which may be of value.

- Clinicians providing this treatment should ensure that appropriate information is supplied at the time of discharge. They should plan ahead for exchange of nephrostomies and ensure patients have a forward plan.

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.