SPSO decision report

Case: **202001654, Borders NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) who had a history of superficial bladder cancer (early bladder cancer when the cancer cells are only in the inner lining of the bladder and has not spread beyond it) and prostate cancer. C complained about the care and treatment provided during two short admissions to Borders General Hospital. A was passing blood in their urine and had unexplained pain. C specifically complained that A was not thoroughly assessed and that further investigations should have been carried out. A chest x-ray was later performed which identified a shadow on A's lung. A's condition deteriorated and they died a few weeks later.

The board confirmed that they considered the care and treatment provided to be reasonable and that there was no suggestion at the time to indicate that further tests were necessary.

We took independent advice from a consultant uro-oncologist (a specialist in diagnosing and treating cancers of the male and female urinary tract and the male reproductive organs) with a speciality in dealing with bladder and prostate cancer. We found that there was a failure to take the appropriate action in response to the findings of a previous cystoscopy (bladder examination using a narrow tube-like telescopic camera) which showed a thickened bladder, and that during the first admission it was incorrect to state that the findings of this procedure were normal. We also considered that the board failed to fully investigate the cause of A's bleeding, nor the thickened bladder, and that not enough regard was given of A's deterioration. We upheld the complaints, concluding that these failings led to a delayed diagnosis of A's cancer. However, we acknowledged that these failings did not impact on A's ultimate prognosis.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the identified failings. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Staff should fully understand the importance of taking into account the patient's medical history, accurately report on previous test results and ensure that symptoms are fully investigated.

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.