SPSO decision report

Case: **202004331, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided by the board to their late spouse (A) who was diagnosed with muscle-invasive bladder cancer. C complained about various aspects of the care that A received. These included delay, and ultimate failure, to carry out surgery to remove A's bladder, inappropriately high and missed doses of medication, and initial refusal to offer chemotherapy (a treatment where medicine is used to kill cancerous cells). C also complained about a failure by an out of hours doctor in identifying a deep vein thrombosis (DVT, a blood clot in a vein) that A developed and subsequent provision of insufficient information on medication used to treat the DVT. C further complained about various failures of communication as well as concerns about arrangements for visiting A due to the Covid-19 pandemic and end of life care.

We took independent advice from medical advisers with expertise in oncology (cancer specialist), urology (a specialty in medicine that deals with problems of the urinary system), general practice and community nursing. We found that A's pain medication regimen was reasonable and that the timescale for the scheduling of A's bladder removal surgery had been appropriate. We also found that decisions made about the timing of chemotherapy and communication with A had been reasonable. This included communication about A's end of life care and how rules relating to visiting A during the pandemic had been applied.

However, a number of failings in the treatment provided to A were also identified. We found that A had not been given appropriate information on the extent of their cancer, the prognosis and the potential treatment options. We also found that there had been an unreasonable delay in the discussing of A's case by the board's multi-disciplinary team, which also understated the extent of A's cancer. Furthermore, we found that A missed doses of regular medication when attending for palliative chemotherapy, that the DVT A developed was unreasonably not initially identified and, once diagnosed, insufficient information was given to A about medication given to treat the DVT.

For these reasons, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Patients diagnosed with DVT should be given appropriate information on anticoagulants (drugs that reduce the body's ability to form clots in the blood), in line with relevant clinical guidance.
- Patients should be given a comprehensive assessment of their end of life care needs, including support for sleeping, which is then clearly recorded in their nursing records.

- Patients should be given timely, clear and accurate information about the extent of their cancer, prognosis and management options. Patients should also receive appropriate support from clinical nurse specialists, in line with relevant clinical guidance.
- Patients requiring urgent care should be referred to specialists within a reasonable timeframe.
- Patients should be appropriately referred to the multidisciplinary team within a reasonable timeframe.

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.