SPSO decision report

Case: **202004419, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the standard of medical treatment provided to their late spouse (A) by the board following diagnosis and treatment of upper tract urothelial cancer (a type of kidney cancer). A's condition deteriorated and they died. C complained that clinicians failed to, amongst other things, communicate with them in a reasonable way about treatment options and take reasonable action in response to A's clinical condition.

We took independent advice from a urology specialist (concerning the male and female urinary tract, and the male reproductive organs) and a renal specialist (concerning the kidneys). We found that A's cancer had likely been more aggressive than originally suspected. However, given the information available at the time, the option of treatment offered to A had been a reasonable approach. We also found that the board had failed to adequately document that all treatment options had been discussed with A, and that a specialist renal cancer nurse should have been available to the family sooner. We found that had A's treatment been carried out sooner (and in line with cancer waiting time standards), it may have improved their health outcomes. For these reasons, we upheld this aspect of C's complaint.

C also complained that during a hospital admission the board had failed to reasonably manage the removal of A's nephrostomy tube (a catheter inserted through the skin and into the kidney) causing them to suffer an arterial trauma (or bleed). We found that bleeding is a recognised complication of such a procedure and there was no evidence to indicate any failings in the removal of the tube. We did not uphold this aspect of C's complaint.

C further complained that when A's condition deteriorated following dialysis, unit staff advised the family to take A home, or to take them to the emergency department themselves. C also complained that there had been no end-of-life plan in place for A. We found that there was insufficient evidence to determine what advice had initially been offered to the family by unit staff. However, we found that the process around the decision-making to admit A for ward care had been appropriate, and although there had been no end-of-life plan in place, the 'wait and see' approach to treatment had been reasonable in this case. Therefore, on balance, we did not uphold this aspect of C's 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:

- The board should ensure all discussions between patients and clinicians are clearly documented in line with required standards.
- The board should give consideration to the use of specialist renal cancer nurses in supporting patient

diagnosis/patient management from an early stage.
- The board should review urgent suspicion of cancer referrals to address treatment waiting times, ensuring that there are appropriate mechanisms in place to monitor progress from diagnosis to definitive treatment.

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.