

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO

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Scottish Parliament Region: Mid Scotland and Fife

Case ref: 201602341, Fife NHS Board

Sector: Health

Subject: Hospitals / Clinical treatment / Diagnosis/Complaints handling

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr C) by Fife NHS Board (the board). Mrs C's complaint related to delay in diagnosing that Mr C had lung cancer and the treatment provided to Mr C. Mrs C complained that the standard of care Mr C had received had been poor.

We took independent advice from a consultant respiratory physician. We found that Mr C was high risk for lung cancer, given his history as a former smoker with a background of heavy exposure to asbestos, and presenting with a cough and breathlessness. There were also concerning features in Mr C's radiology results and his case was complex. Despite this, Mr C was removed from an expedited cancer referral pathway without his case being discussed at a lung cancer multi-disciplinary team (MDT) meeting and without consideration given to a tissue biopsy being carried out. There was also no evidence that there had been any discussion with Mr C to enable him to make an informed decision about his future treatment. We also considered that the board did not appear to have followed national standards and guidelines in Mr C's case.

The advice we received was that this represented serious failings in Mr C's care and treatment and that if such action had been taken, this could potentially have resulted in a different outcome for Mr C. As such, we upheld this complaint. The board have told us they now have systems and processes for patients in a similar situation to Mr C which they say are significantly different from what was previously in place and are willing to have their lung cancer service independently audited and peer reviewed. In view of the failings we identified, we made a number of recommendations to address this.

Mrs C also complained about the palliative nursing care Mr C received following his cancer diagnosis. We took independent nursing advice. We found that although the board had taken action following Mrs C's complaint, the advice we received was that there were serious failings in the nursing care provided to Mr C following his cancer diagnosis which had not been identified or addressed by the board. There had been a failure to comply with professional and clinical

standards for practice which would be expected of the nursing staff and the palliative care provided had fallen below the standards which Mr C and his family should have reasonably expected. We upheld this complaint and made a number of recommendations to address the issues identified.

Mrs C also complained that the board's handling of her complaint was inadequate. We were satisfied there were failings in how the board responded to Mrs C's complaint and upheld this part of her complaint. We made recommendations to address these failings.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b), (c)	<p>There were serious failings in diagnosing that Mr C had lung cancer and in the treatment he received.</p> <p>There were serious failings in the nursing care provided to Mr C after his cancer diagnosis in June 2015.</p> <p>There were failings in the Board's handling of Mrs C's complaint</p>	<p>Apologise to Mrs C for the failings in: Mr C's diagnosis and treatment; the nursing care provided to Mr C after his cancer diagnosis in June 2015; and the handling of Mrs C's complaint.</p> <p>The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spsso.org.uk/leaflets-and-guidance</p>	<p>A copy or record of the apology</p> <p>By: 21 March 2018</p>

We are asking The Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Mr C was unreasonably removed from the expedited lung cancer referral pathway without his case being discussed at a lung MDT meeting, which led to a delay in diagnosing that he had lung cancer. This adversely impacted on Mr C's outcome	Patients who present with suspected lung cancer symptoms should not be removed from the expedited lung cancer referral pathway without the case being discussed at a lung MDT meeting	<p>A copy of the current systems and processes in place on the removal of patients from the cancer referral pathway showing they take into account national guidance and the appropriate process for discussion at a lung MDT meeting.</p> <p>Evidence of the review of patients who were removed from the referral pathway in the same year as Mr C.</p> <p>Evidence that the Board has carried out an independent and impartial review of the lung cancer service which includes considering the appropriateness of any decision to remove a patient from the lung cancer care pathway without an MDT meeting being held. The evidence is to include providing SPSO with a briefing document outlining the scope of the review; who will be carrying out the review; and a report on the outcome of the review.</p>

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
			<p>Evidence that this report has been shared with relevant staff and managers in a supportive way for reflection and learning</p> <p>By: 21 August 2018</p>
(a)	<p>There was a failure to involve Mr C in making an informed decision about his treatment</p>	<p>Patients should be fully informed and involved in decisions about their treatment</p>	<p>Evidence that this report has been shared with relevant staff and managers in a supportive way for reflection and learning</p> <p>By: 23 April 2018</p>
(a)	<p>There was a failure to refer Mr C to a lung MDT meeting when cancer was diagnosed and it became apparent that the skin lesion was metastatic</p>	<p>Patients should be appropriately referred to a MDT meeting.</p>	<p>Evidence that patients are being appropriately referred for discussion at MDT meetings within the lung cancer service (this could be evidence provided as part of the audit referred to above)</p> <p>By: 23 April 2018</p>

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	Mr C and his family did not receive the standard of palliative nursing care and support which they should have reasonably expected to receive	Patients who require palliative nursing care and their families should the receive care and support needed. This should be adequately led, co-ordinated and person-centred	<p>Details of a review of the Palliative Care Service with evidence that any training needs identified as part of the review are being met, or planned (with definitive timescales, not simply a broad intention).</p> <p>Evidence that this report has been shared with relevant staff and managers in a supportive way and that reflection and learning have taken place</p> <p>By: 23 April 2018</p>
(b)	There was a failure by nursing staff to comply with national guidance and standards; in particular, in relation to assessing and managing pain and distress; and maintaining care plans	Nursing staff should ensure that national guidance and standards are adhered to; in particular, in relation to the assessment of pain and distress and managing care plans	<p>Evidence that this report has been shared with relevant staff and managers in a supportive way for reflection and learning</p> <p>By: 23 April 2018</p>

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	There was a failure to comply with NMC and Scottish Government requirements for prescribing	The Board should ensure that systems are in place to ensure that nurse prescribing complies with NMC standards and Scottish Government guidance	<p>Details of the system in place (including procedures or instructions to staff) to ensure the safe prescribing of medicine by all non-medical prescribers which follows NMC and Scottish Government standards and guidance</p> <p>Evidence that the Board have reviewed whether relevant nursing staff have received sufficient training in the prescribing of medication, particularly to address the failings identified in this report and evidence of how training will be kept up to date</p> <p>By: 23 April 2018</p>
(b)	There were omissions in record-keeping in relation to the recording of nursing care provided to Mr C	Nursing records should be maintained in accordance with the nursing and midwifery code of practice and standards	<p>Evidence that the findings of this report have been shared with relevant staff and managers in a supportive way, and what action has been taken as a result.</p> <p>By: 23 April 2018</p>

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(c)	The Board's handling of Mrs C's complaint fell below a reasonable standard	Staff should be aware of the importance of keeping complainants updated and providing a full response	Evidence that the model CHP has been circulated with attention drawn to matters of particular relevance By: 23 April 2018

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(c)	The Board acknowledged that documents relating to a meeting about Mr C's case had not been located during the Board's investigation of Mrs C's complaint	The Board had raised what had occurred with the department responsible and taken action to address how they stored health records; and they were also introducing a new electronic system during 2017 which will provide a single point for all patient information to be logged electronically	Evidence, such as: discussions about what occurred; the changes that have been made; and revised procedures or instructions to staff about the storage of patient information records By: 23 April 2018

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C and her late husband as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to the Ombudsman about the care and treatment provided to her late husband (Mr C) by Fife NHS Board (the Board). Mrs C's complaint related to delay in diagnosing that Mr C had lung cancer; the treatment provided to Mr C between October 2014 and June 2015; and the palliative nursing care he received following his cancer diagnosis in June 2015. Mrs C complained that the standard of care provided had been poor. Sadly, Mr C died in August 2015.

2. Mrs C complained to my office because she was dissatisfied with the Board's response to the concerns she raised about Mr C's care and treatment and with the Board's handling of her complaint.

3. The complaints from Mrs C I have investigated are that:

- (a) the medical diagnosis and treatment provided to Mr C between October 2014 and June 2015 was inadequate (*upheld*);
- (b) the nursing care provided to Mr C after diagnosis in June 2015 was inadequate (*upheld*); and
- (c) the Board's investigation of and response to Mrs C's complaint was inadequate (*upheld*).

Investigation

4. I and my complaints reviewer considered all the information provided by Mrs C and the Board, including Mr C's relevant medical and nursing records and the Board's complaint file. We also obtained independent advice from two advisers: a consultant respiratory physician (Adviser 1) and a nursing adviser (Adviser 2), on the clinical aspects of the complaint.

5. I have decided to issue a public report on Mrs C's complaint. This reflects both my deep concerns about the significant and serious failings identified in Mr C's care and treatment and because I consider it is in the wider public interest. It is also to highlight that public bodies, generally, can take positive steps to put matters right and do not have to wait until my office issues decisions.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The medical diagnosis and treatment provided to Mr C between October 2014 and June 2015 was inadequate

Concerns raised by Mrs C

7. Mr C was referred by his General Practitioner (GP) to Victoria Hospital, Kirkcaldy (the Hospital) because he had a chronic cough in September 2014. Mrs C said that x-rays and scans carried out in 2014 and early 2015 showed significant changes in Mr C's chest and lung. However, despite these changes, Mr C was told by a consultant respiratory physician (Doctor 1) that he had asthma and no further scans were required. Doctor 1 removed Mr C from an expedited cancer referral pathway (the referral pathway).

8. Mrs C said that Mr C's condition then deteriorated and he developed cancerous skin lesions. In June 2015, Mr C was diagnosed with metastatic lung cancer, by which time he was in extreme pain. Mr C, thereafter, received palliative care until his death in August 2015.

9. Mrs C questioned the care and treatment Mr C had received. In particular, why Doctor 1 told Mr C that he had asthma and that no further investigations required to be carried out and why Mr C had been removed from the referral pathway. Mrs C considered that Mr C's condition had been misdiagnosed, which she believed had led to a rapid deterioration in his health and subsequent early death.

The Board's response

10. In response to Mrs C's complaint, the Board said Mr C was initially referred by his GP in early September 2014 with a chronic cough. It was noted his chest x-ray was abnormal. As a result of the GP referral letter, a CT scan was carried out in October 2014, which showed changes in Mr C's chest in keeping with past asbestos exposure. There was some thickening and some fluid around the bottom of Mr C's right lung and an area of abnormality within the lung which was considered to be an area of rounded atelectasis, which the Board explained is a patch of compressed and deformed lung due to adjacent lung changes. A repeat scan after three months was suggested.

11. As a result of these findings and the available information to hand on Mr C's case, Doctor 1 took the decision to remove Mr C from the referral pathway knowing that he would be seen at an out-patient clinic when, among other things, the findings of the CT scan could be discussed as well as the reasons for the repeat scanning. The Board explained that the referral pathway is one which

patients with suspected cancer follow after a referral by their GP to the respiratory team.

12. The Board said Mr C was seen by Doctor 1 in November 2014. At that time Mr C said he had a wheeze and a persistent cough and, as there was evidence he had airway narrowing, these features made Doctor 1 consider that Mr C's symptoms were a consequence of late onset asthma and gastroesophageal reflux. It was noted that Mr C's weight was steady, his blood test results were normal and he was not in pain. Doctor 1 was aware of Mr C's exposure to asbestos and this was taken account of in the context of the CT scan findings. The Board said Doctor 1 was comfortable with his diagnosis and that he had informed Mr C's GP that if his symptoms failed to settle he would see him again.

13. In January 2015, Mr C underwent repeat scanning of his chest, the results of which remained abnormal but without any new changes. The Board said Doctor 1 considered the fact that there were no new changes and the appearance at the bottom of Mr C's right lung remained in keeping with an area of rounded atelectasis was important. On the basis of this, Doctor 1 had written to Mr and Mrs C in February 2015 to advise them there were no new changes. Doctor 1 said this was not the same as stating that Mr C's scan results were normal.

14. In February 2015, Mr C was referred by his GP to the Board's general surgery department because of what appeared to be a sebaceous cyst on his forehead. This was biopsied in April 2015 and removed in June 2015. The Board said this cyst was subsequently diagnosed as cancer and was the first sign that Mr C's lung cancer had spread. The Board said this was not shared, however, with Doctor 1 until Mr C re-presented to the acute medicine department in June 2015 with bone pains, which was a consequence of the spread of the cancer.

15. The Board said that Mr C's case was then discussed at a lung multi-disciplinary team (MDT) meeting held in mid-June 2015. It was decided that Mr C would be reviewed at a chest out-patient clinic, his symptoms were to be assessed and a biopsy carried out. Mr C was admitted to the Hospital for symptom control and reviewed by a lung cancer specialist at the end of June 2015.

16. The Board said that Doctor 1, when reviewing Mr C's case following Mrs C's complaint, had considered whether they could have done anything differently when Mr C was seen in the out-patient clinic in November 2014. Doctor 1 said

that the only change they would have made would have been to consider a biopsy of the abnormality at the bottom of Mr C's right lung. Doctor 1 said that while a number of patients presented with rounded atelectasis in the context of asbestos exposure, only a very few of these patients were ever biopsied. Doctor 1 explained that a biopsy was carried out when there was a change in appearance or other concerning features. Doctor 1 considered, however, there was none in Mr C's case in November 2014. Doctor 1 also considered there was no indication at that time for carrying out a biopsy, which would not have been without some risk.

17. The Board said when Doctor 1 reviewed the available information in relation to Mr C's case the only abnormality they found was in the result of one of the blood tests, plasma viscosity; which is the measurement of the amount of protein present in the plasma (liquid) part of the blood and can reflect inflammation in the body. This was elevated. Doctor 1's view was that this could have been due to many reasons, including the presence of a cancer but also the sign of an infection.

18. Doctor 1 acknowledged that while Mr C's lung cancer must have been present when he saw Mr C in November 2014, it was not clear from either Mr C's clinical history or results. Had Doctor 1 been aware of the squamous cancer in a new nodule in Mr C's forehead in February 2015, it may have been appropriate to reconsider Mr C's treatment plan in light of this additional diagnosis earlier than June 2015. On reflection, Doctor 1 considered that a discussion regarding a further scan after an interval would have been helpful. However, by June 2015 Mr C had re-presented with bone pain.

19. The Board said they had also asked their Clinical Director for Emergency Care (Doctor 2) to review Mr C's care and treatment. In carrying out this review, Doctor 2 had discussed Mr C's case with Doctor 1. The Board said that in Mr C's case his first CT scan in November 2014 did not demonstrate any obvious lung cancer, hence the reason his treatment pathway was changed. The CT scan carried out three months later showed that the abnormality at the bottom of Mr C's right lung appeared stable. The Board said this would have provided reassurance that this abnormality was unlikely to be lung cancer although, subsequently, this was shown not to be the case.

20. Doctor 2 agreed with Doctor 1 that while a further CT scan to monitor the abnormality may have been appropriate, this was unlikely to have altered

subsequent events. This was because by February 2015, in spite of the recent unchanged CT scan, there was evidence of cancer in Mr C's skin which was subsequently diagnosed as metastatic lung cancer. By the time Mr C was discussed at a lung MDT meeting in June 2015, there was evidence he had advanced cancer.

21. When commenting on a draft of this report, the Board told me that their systems and processes for patients in a similar situation to Mr C are now significantly different from the time when Mrs C made her complaint. The Board also informed me they have carried out a review of all patients who were removed from the referral pathway in the same year as Mr C and are willing to have their lung cancer service audited and peer reviewed as required. While this cannot change Mr C's and his family's experience, I am encouraged that the Board have taken positive steps to try to avoid a recurrence for others.

Medical advice

22. Adviser 1 told us that Mr C's GP was clearly concerned that he possibly had lung cancer and, because of this, had made an appropriate urgent referral to Doctor 1.

23. Adviser 1 told us that Mr C had initially been reviewed in a timely manner and a chest x-ray and a CT scan were carried out in September 2014 and October 2014 respectively. There were changes in the chest x-ray from a previous x-ray carried out in April 2014. Adviser 1 also considered there were concerning features in Mr C's CT scan result. Adviser 1 explained to us that the CT scan had shown small effusion and pleural changes which could have represented mesothelioma or pleural spread of cancer and an area of rounded atelectasis which may have represented a mass lesion.

24. Adviser 1 said it was unclear from the medical records whether a radiologist had known Mr C's history when they reviewed the radiology results and also whether Doctor 1 had access to all of the radiology reports. Doctor 1, however, rather than investigating the possibility that Mr C had lung cancer, had taken the view he had a benign prognosis, asthma, and removed him from the referral pathway in November 2014. Before doing so, Doctor 1 had not referred Mr C's case for discussion at a lung MDT meeting, as they would have expected (Adviser 1 noted that such MDT meetings were held during this time).

25. Adviser 1 told us that they did not agree with the decision to remove Mr C from the referral pathway. This was because, in their view, Mr C was a high risk patient for lung cancer as he was a former smoker with a background of heavy exposure to asbestos and had presented with a cough and breathlessness. Adviser 1 explained to us that there was more than a ten-fold risk of lung cancer in persons exposed to asbestos additional to the risk of smoking and who had presented with an abnormal and altered chest x-ray and an abnormal CT scan.

26. Adviser 1 said Mr C's case was high risk and complex and they would have expected it to have been discussed at a lung MDT meeting for a considered opinion after the CT scan was carried out.

27. Adviser 1 said, from his review of Mr C's medical records, that when Doctor 1 saw him in November 2014 a diagnosis of asthma was discussed and treatment for this condition with a trial of steroid medication was started. However, Adviser 1 told us they could see no confirmation from the results of laboratory tests carried out or in Mr C's response to the steroid treatment that Mr C had asthma. Adviser 1 said these tests suggested that Mr C had severe airflow obstruction and also the possibility he had restrictive lung disease. Adviser 1 said, however, that full lung function tests were required to confirm this. Such tests would also have brought into contention other different diagnoses than asthma. There was no evidence of these tests having been requested.

28. Adviser 1 said consideration should also have been given to tissue sampling at this time: if a tissue biopsy had been carried out in October / November 2014, it may have been negative or inconclusive. If a tissue biopsy had been diagnostic for non-small cell lung cancer there were possible treatment options which could have been considered at this time. Adviser 1 said, as a best case scenario, thoracic surgery though complex could have been considered and possibly may have been curative, although unlikely. While combined chemotherapy / radiotherapy treatment was unlikely to be curative, although possible, Adviser 1's view was that it was probable that with this treatment Mr C's prognosis could have been considerably better with an improved survival time.

29. Adviser 1 considered there should have been a joint discussion with Mr C, in particular, to explain to him the complexity of his case and in order that he could make a fully informed choice about the next steps in his treatment and give consideration to tissue sampling. Although Mr C might have decided not to take investigations further faced with an uncertain outcome, this should have been a

decision for him to make, informed by the discussion of his case at a lung MDT meeting.

30. Adviser 1 told us that it appeared the Board's process for referring cases to a lung MDT meeting did not operate under current national guidance in relation to referring a patient's case for review.

31. Adviser 1 explained that as Mr C's case was complex and high risk, it met the criteria for review in terms of the Scottish Intercollegiate Guidelines Network (SIGN) 137 Management of lung cancer (SIGN 137); in particular, sections 4.1, 4.22 and 4.4. SIGN 137 states that:

'contrast enhanced CT scanning of the chest and abdomen is recommended in all patients with suspected lung cancer, regardless of chest x-ray results' and 'a tissue diagnosis should not be inferred from CT appearances alone'. Also, 'contrast enhanced CT scanning of the chest and abdomen should be performed prior to further diagnostic investigations ... and the results used to guide the investigation that is most likely to provide both a diagnosis and stage the disease to the highest level.'

32. Adviser 1 referred us to Sections 6 and 12 of the United Kingdom Lung Cancer Coalition (a coalition of the UK's leading lung cancer experts, senior NHS Professions, charities and healthcare companies) Lung Cancer Quality Standard. Section 6 states that:

'every patient has their case discussed by a specialist lung cancer MDT which has a membership that is representative of every relevant discipline and that every healthcare professional in the MDT has a specialism in thoracic oncology'.

Section 12 states that:

'the diagnostic and staging pathway is planned at the earliest possible time within the referral pathway to allow timely access to diagnostics. This pathway is designed to allow the safest and most informative diagnosis, including the type and the extent of the cancer, with the fewest tests.'

33. Adviser 1 also referred us to National Institute for Health and Care Excellence (NICE) clinical guideline [CG 121] Lung cancer: diagnosis and management; in particular, sections 1.3.31, 1.3.32 and 1.3.33, which recommends that all patients with a likely diagnosis of lung cancer should be discussed at a lung cancer MDT meeting.

34. Adviser 1 told us that, given Mr C's case was complex and he was high risk for lung cancer, the following points all represented serious failings in Mr C's care and treatment:

- not to have discussed his case at a lung MDT meeting;
- not to have considered tissue sampling;
- the decision by Doctor 1 to remove Mr C from the referral pathway; and
- not to have had a discussion with Mr C regarding the next steps in his treatment.

35. Adviser 1 said that Mr C had then presented with skin lesions and a diagnosis of cancer from a skin biopsy was made between April and May 2015. Ideally, Mr C should then have been referred to a lung MDT meeting, when it became apparent that the skin lesion was metastatic. Adviser 1 went on to say that that if Mr C had been seen by a lung oncologist between April and May 2015, while it was unlikely to have altered his outcome very significantly as by then his cancer was metastatic and incurable, his survival may have improved by two to three months.

36. Adviser 1 told us that, given his concerns that Mr C had been removed from the referral pathway without his case being reviewed at a lung MDT meeting, they questioned whether this had occurred with other patients.

37. Adviser 1's view was that the Board should consider carrying out an independent expert audit and peer review of their lung cancer MDT meetings and lung cancer service, in order to understand the reasons for and the frequency with which patients are removed from the referral pathway without discussion at a lung MDT meeting. The review should then advise on the appropriateness of the approach.

38. Adviser 1 also told us that it was important to understand whether the Board had an effective policy in place on the removal of patients from the referral pathway.

(a) Decision

39. The basis on which we reach decisions is reasonableness. We consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question.

40. The advice I received from Adviser 1 is that Mr C was high risk for lung cancer, given his history as a former smoker with a background of heavy exposure to asbestos, and presenting with a cough and breathlessness. There were also concerning features in Mr C's radiology results and his case was complex. Despite this, Mr C was removed from an expedited cancer referral pathway without his case being discussed at a lung MDT meeting and without consideration given to a tissue biopsy being carried out. There was also no evidence that there had been any discussion with Mr C to enable him to make an informed decision about his future treatment following the CT scan.

41. Adviser 1's view was this represented serious failings in Mr C's care and treatment and that if such action had been taken, this could potentially have resulted in a different outcome for Mr C. I accept this advice.

42. Mr C was subsequently diagnosed with cancerous skin lesions, as a result of Mr C's lung cancer metastasizing. I accept Adviser 1's advice that, ideally, at this time Mr C's case should have been referred to a lung MDT meeting and Mr C seen by a lung oncologist. While it was unlikely to have altered Mr C's outcome very significantly as by then his cancer was incurable, his survival may have improved by several months time.

43. I am critical of the serious failings identified in Mr C's care and treatment. I appreciate the distress which will be caused to Mrs C and her family to learn of this and that earlier action might, potentially, have afforded Mr C the chance of an alternative outcome; at the very least, an improved survival time.

44. I am also concerned that the Board did not appear to have followed national standards and guidelines in Mr C's case.

45. Having considered all of this, I uphold this complaint.

46. I am pleased that the Board now have systems and processes for patients in a similar situation to Mr C which they say are significantly different from what was previously in place. It is reassuring the Board have carried out a review of all patients who were removed from the referral pathway in the same year as Mr C and are willing to have their lung cancer service independently audited and peer reviewed.

47. I have made recommendations to address the failings identified. These will be followed up to ensure the Board does, or has done, what they said they would as a result of my investigation. The aim of these recommendations is to prevent others experiencing what Mr C and his family experienced. My recommendations are listed at the end of this report.

(b) The nursing care provided to Mr C after diagnosis in June 2015 was inadequate

Concerns raised by Mrs C

48. Mrs C complained about the palliative nursing care provided by a community specialist palliative care nurse (Nurse 1) and a senior nurse (Nurse 2) following Mr C's cancer diagnosis in June 2015.

49. Mrs C said Nurse 1 had informed Mr C's GP they would visit Mr C on a regular basis but this did not happen. Mrs C said Nurse 1 had only visited Mr C once, in July 2015: as a result, the family had felt abandoned at an incredibly difficult time.

50. Mrs C said, on one particular occasion, Mr C had contacted Nurse 1 about a lump which had developed near his ear and was causing him severe pain and discomfort. Nurse 1 had advised Mr C to contact his GP although they understood that Nurse 1 was their point of contact for this kind of support.

51. Mrs C said there had been errors in record-keeping by Nurse 1 who had recorded in Mr C's medical records that he had stopped smoking in February 2015, although he had stopped thirty years earlier. Additionally, Nurse 1 had recorded that they had contact with Mr C on 30 July 2015, which was wrong as Mr C was in a hospice at this time.

52. Mrs C said Nurse 2 attended Mr C's out-patient clinic appointments and had been introduced as a point of contact for support for Mr C and his family. Mrs C said that during a clinic appointment, Nurse 2, who was a prescribing nurse, was requested by the doctor taking the clinic (Doctor 3) to complete a prescription for dexamethasone tablets for Mr C.

53. Mrs C said that the prescription completed by Nurse 2 had been rejected by a local pharmacist as it contained a number of errors and a new prescription had to be prepared. Mrs C said that when her daughter (Ms A) contacted Nurse 2

about the problems with the prescription, Nurse 2 had acted in a defensive manner.

54. Mrs C said the input of both Nurse 1 and Nurse 2, which was meant to have been supportive to Mr C and their family, had instead caused them confusion and distress.

The Board's response

55. The Board said Mr C was referred to the Palliative Care Service on 30 June 2015. Nurse 1 had made contact with Mr C the same day of his referral but did not see him as he had been attending an oncology appointment. Nurse 1 had then contacted Mr C on 1 July 2015 and arranged to visit him the following day. As a result of this visit, Nurse 1 had contacted Mr C's GP to organise physiotherapy for him at home and made a referral concerning Mr C's entitlement to financial benefits.

56. The Board said Nurse 1 had then telephoned Mr C on 9 July 2015 but was advised that he was resting as he was exhausted following treatment. Therefore, Nurse 1 had agreed to call again following Mr C's oncology review the following week.

57. The Board said, in their initial written response to concerns raised by Mrs C, that Mr C had contacted Nurse 1 on 30 July 2015 to discuss a lump causing him discomfort near his ear and said he had been seen by a dermatologist. (In the Board's subsequent response to Mrs C they said there had been a typographic error in their initial response and the correct date of contact should have stated 13 July 2015, not 30 July 2015. I have addressed this error in more detail in complaint (c)). Nurse 1 was unable to visit Mr C that day but had suggested that if his pain relief was not effective he could contact his GP, which Mr C agreed to do. Mr C was also agreeable to telephone contact later that week and to Nurse 1 visiting him as required.

58. Nurse 1 had then contacted Mr C by telephone on 16 July 2015 and 22 July 2015 but there was no reply. On 27 July 2015, Nurse 1 was informed that Mr C was being admitted to the hospice as he had been less well over the previous weekend.

59. The Board said the Palliative Care Service had reflected on their practice. They regretted that Mrs C had not felt supported during what was a difficult time

for Mr and Mrs C and their family. They had reviewed their practice of not always leaving a voice message as they were now aware of the need to do this to make sure patients and their families knew the Palliative Care Service had been in contact and that they could call back if required.

60. The Board said they had also discussed Mrs C's concerns about Nurse 2 directly with them. Nurse 2 had confirmed meeting Mr C in the oncology clinic with Doctor 3, at which time they had been asked to complete a prescription for dexamethasone tablets. Nurse 2 fully acknowledged that there was an issue in terms of the completion of the prescription and its legibility. Nurse 2 was sorry for any confusion caused and that they had come across as defensive when speaking to Ms A, which was not their intention. Nurse 2 had apologised for the further distress caused.

61. The Board said the Palliative Care Service had recognised that Mrs C might require support following Mr C's death and had, therefore, sent her a letter in September 2015 offering counselling support.

Nursing advice

62. Adviser 2 said an urgent referral was made by Mr C's GP in June 2015 to the Palliative Care Service. The referral reported Mr C, as having uncontrolled pain and reduced mobility. It also noted that Mr C was 'quite angry' that his cancer was not picked up on when he was scanned. Following the referral, an initial telephone contact was made by Nurse 1, who then assessed Mr C at his home three days later.

63. Adviser 2 noted there was an entry made by Nurse 1 11 days after their initial visit to Mr C, in which they had advised Mr C to contact his GP with regard to a painful lump near his ear. Adviser 1 said this was in spite of a request from Mr C that Nurse 1 discuss his concerns about the lump with the GP. Adviser 2 told us that, as the specialist palliative care nurse for Mr C, it seemed reasonable that Nurse 1 would be the co-ordinating professional and work with Mr C and his family as they negotiated a number of referrals and specialist services.

64. Adviser 2 said the assessment documentation completed by Nurse 1 was incomplete; there was no evidence of any self-reporting pain chart or pain scoring. Adviser 2 said that the pain assessment and the pain management plan available in Mr C's records did not comply with SIGN guideline 106 - Pain in

Adults with Cancer (SIGN 106) and Scottish Palliative Care Guidelines 2013 (the Scottish Palliative Care Guidelines).

65. Adviser 2 said Section 4.4.2 of SIGN 106 states that:

'patients with cancer pain should have treatment outcomes monitored regularly using visual analogue scales, numerical rating scales or verbal rating scales.'

And that Section 4.4.3 recommends that:

'pain assessment should be carried out regularly (at least daily when pain is not adequately controlled).'

66. Adviser 2 said both Section 4.4.2 of SIGN 106 and the Scottish Palliative Care Guidelines recommend the use of pain assessment tools and the recording of pain scores and that pain charts to be left with the patient for regular updating should also be considered. The Scottish Palliative Care Guidelines also recommends that patients and families are given clear guidance on what to expect and on how to access help, especially out-of-hours. In addition, Section 4.4.3 of SIGN 106 recommends that 'pain assessment should be carried out regularly (at least daily when pain is not adequately controlled).'

67. Adviser 2 told us that Nurse 1 should have detailed a more comprehensive assessment of the pain and distress that Mr C was experiencing. The assessment should have included a robust pain assessment, including a patient self-assessment tool, as well as screening for psychological distress. This assessment should have been accompanied by a clear and specific care plan which detailed the actions, support and follow-up arrangements which should have been agreed with Mr C and his family. There was, however, no evidence of further pain assessment having been carried out following Nurse 1's initial visit.

68. Adviser 2 said Section 3.1.1 of Sign 106 recommends that:

'comprehensive chronic pain assessment should include routine screening for psychological distress.'

69. Adviser 2 could find no record that the psychological distress that Mr C was experiencing was assessed. Also there was scant evidence of interventions to assess and to deal with the psychological distress related to Mr C's condition. In view of Mr C's history, it seemed appropriate to have engaged counselling /

psychology services at an earlier stage. Adviser 2 noted a referral was only made following Mr C's death.

70. It was also not clear from the records what Nurse 1's role was with Mr C and his family. Although Nurse 1 had noted that anger, pain control issues and concern about lack of co-ordination were Mr C's main concerns, there was no clear record as to how they would help to address these.

71. Adviser 2 said there was a lack of communication with Mr C and his family. Nurse 1 had noted in Mr C's records that they would visit him again 'when able': Adviser 2 considered this was not appropriate. In Adviser 2's view, Nurse 1's management plan did not make clear the plans for review of Mr C and how he could contact them. Adviser 2 said that Nurse 1 should have been much clearer with Mr C and his family as to the specific arrangements for review, considering that Mr C's pain was not controlled at the time of their initial visit.

72. Adviser 2 said this had caused uncertainty for Mr C and his family about who to communicate with and what to expect. Adviser 2 also considered that the nursing records did not demonstrate empathy and understanding of Mr C's condition and concerns, or for the experience that he and his family were going through. Given Mr C's experience of late diagnosis and terminal illness, there was recognised stress and anger for him and his family.

73. Adviser 2 said the Board should, therefore, review the Palliative Care Service with a view to improving the pathways for assessment and care management in order to deliver a person centred, caring and compassionate service for people in the late stages of life. The Board should ensure that Nurse 1 and all other nurses delivering palliative care follow SIGN 106. This should include having the right level of training and ongoing professional development, as well as the appropriate assessment and care planning tools available.

74. Adviser 2 said the Board should also ensure that nurses delivering palliative care have the right knowledge, skills and resources to assess psychological distress for patients and families and to take appropriate actions depending on their findings.

75. Adviser 2 noted that Mr C was seen at an out-patient clinic on several occasions by Nurse 2. However, as the entries in the records were not initialled it was impossible to verify that Nurse 2 had seen Mr C on all of these occasions.

The assessment document for Mr C has not been completed and the action plan section was blank. It was, therefore, Adviser 2's view that it was not possible to understand what the plan of care was for Mr C.

76. Adviser 2 said what was clear from the evidence provided by the Board was that Nurse 2 had seen Mr C at an out-patient clinic on 30 June 2015, when the prescription for dexamethasone was issued. But it was unclear who was responsible for deciding on the dexamethasone treatment. From Nurse 2's statement, in response to Mrs C's complaint and from the Board's response to the complaint, it appeared to Adviser 2 as though Nurse 2 may have written the prescription under the instruction of Doctor 3.

77. Adviser 2 said there was no evidence that an assessment of Mr C was carried out prior to writing the prescription, the outcomes of this assessment, why this treatment was being prescribed, the planned treatment regime and the communication and information given to Mr C to ensure that he understood the reason for this treatment and how to take the medicine safely. None of this information was recorded in Mr C's records as it should have been. Adviser 2 noted that all that was recorded was that Ms A wanted him to have this medication.

78. Adviser 2 explained that if Doctor 3 prescribed this treatment, they should also have completed the prescription. If Nurse 2 was writing this prescription under instruction from Doctor 3, then Nurse 2 should have made clear in the records that they agreed with Doctor 3's treatment decision and why the medication was being prescribed.

79. Adviser 2 said the prescription which Nurse 2 had written was not processed by the pharmacist because it contained the wrong information and was ambiguous. Following this, it appeared that Mr C's GP had completed another prescription for dexamethasone. Adviser 2 considered that Nurse 2's statement lacked recognition of the potentially serious impact which the ambiguous prescription may have had if dispensed. It also lacked reflection on the impact their errors might have had on the confidence that Mr C and his family might have in their ability to care safely for him.

80. Adviser 2 referred us to the Nursing and Midwifery Council (NMC) Standards of proficiency for nurse and midwife prescribers. Sections 3.1 and 3.2 state that:

'in order to prescribe for a patient / you must satisfy yourself that you have undertaken a full assessment of the patient / client, including taking a thorough history and, where possible, a full clinical record. You are accountable for your decision to prescribe and must prescribe only where you have relevant knowledge of the patient / client's health and medical history.'

81. Adviser 2 also referred to the section headed 'Practise effectively' of the NMC Code: Professional standards of practice and behaviour for nurses and midwives. This states that:

'you assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.'

82. Adviser 2 also referred us to the Scottish Government Guidance for Independent Prescribers 2006, Guidance for Nurse Independent Prescribers. Section 95 states that:

'best practice suggests that the details of any prescription, together with other details of the consultation with the patient, should be entered into the shared patient record immediately, or as soon as possible after the consultation. Only in very exceptional circumstances should this period exceed 48 hours from the time of writing the prescription. This information should also be entered at the same time onto the patient record and onto the nursing patient record (where a separate nursing record exists).'

83. Adviser 2 said they considered Nurse 2 had not complied with the relevant NMC and Scottish Government standards and guidance when completing the prescription. This was because they had failed to follow prescribing guidance, to complete records and reflect on the impact of their practice appropriately.

84. Additionally, Adviser 2 considered that Nurse 2's statement (a copy of which was provided to my office by the Board) did not recognise their failure to comply with NMC and Scottish Government guidance on nurse prescribing. Adviser 2's view was that Nurse 2's actions represented a serious failing in practice.

85. In view of what occurred, Adviser 2 considered that the Board should have taken further action to ensure that Nurse 2's clinical knowledge and competence met the prescribing and record-keeping standards of the NMC and Scottish Government standards and guidance. In doing so, they should also have audited Nurse 2's nursing records and prescriptions to identify if there were any previous prescribing and record-keeping failings.

86. Adviser 2 said the Board should, therefore, ensure that Nurse 2's clinical knowledge and competence meets the prescribing standards of the NMC code and standards and Scottish Government guidance for independent prescribers. As part of this, they should audit Nurse 2's nursing records and prescriptions to identify whether there were any previous prescribing failings. The Board should also ensure that they have the right governance systems in place to ensure safe prescribing of medicines by all non-medical prescribers to follow NMC Code and standards and Scottish Government guidance for independent prescribers.

87. Adviser 2 pointed out that the palliative care support provided to Mr C before his admission to the Hospital at the end of July 2015 involved many professionals and services. While there was evidence that individuals responded to Mr C's needs and symptoms he expressed at out-patient clinics, his overall care lacked co-ordination, leadership, and person centredness. This all led to his care being fragmented. Adviser 2 considered Mr C's symptoms of pain and distress were inadequately assessed and managed and there was no clear evidence of care plans to address this. Nurse 1 and Nurse 2s' record-keeping also fell below an acceptable standard.

88. Adviser 2 also said that although Nurse 1 and Nurse 2 had a number of interactions with Mr C and his family, it appeared as though neither of them communicated with each other throughout this period as they should have done. There was no evidence in the records that demonstrated the family had been informed clearly about who they should deal with.

89. Adviser 2 considered that the nursing care provided to Mr C was not reasonable and there were serious failings in the nursing care provided to him and his family. Adviser 2 told us that the palliative care service provided by Nurse 1 and Nurse 2 fell below the standards which Mr C and his family could have reasonably expected.

90. Adviser 2 also considered that Nurse 1 and Nurse 2 had not displayed appropriate empathy for Mr C and his family nor did they acknowledge learning points derived from the gaps identified.

91. Adviser 2 considered the Board should carry out a review involving all those involved in delivery of palliative care to Mr C, including Nurse 1, Nurse 2 and Doctor 3, to ensure that all learning points are addressed to prevent such recurrences in the future and to improve practice.

(b) Decision

92. I have considered very carefully, and taken into account the evidence Mrs C and the Board provided and the independent advice I have received from Adviser 2, whose advice I have set out above.

93. I acknowledge the action the Board say they have taken following Mrs C's complaint. The advice I have received, however, is that there were serious failings in the nursing care provided to Mr C following his cancer diagnosis in June 2015 which have not been identified or addressed by the Board. I find this concerning.

94. Adviser 2:

- said that Mr C's symptoms of pain and distress were inadequately assessed and managed, including his psychological distress, by Nurse 1 and there was no clear evidence of care plans to address this;
- identified shortcomings in record-keeping by Nurse 1 and failings in communication by Nurse 1 with Mr C and his family, and with others who were also providing Mr C's palliative care; and
- identified failings in relation to the prescription for dexamethasone, including record-keeping by Nurse 2 which fell below an acceptable standard.

I also note Adviser 2's comments that Nurse 2 appears to have failed to recognise not only the potentially serious impact that the ambiguous prescription may have had if dispensed but also on the confidence that Mr C and his family might have in the care he was receiving.

95. While the advice I have also received is that there was some evidence that staff had responded to Mr C's needs and symptoms, it appears his overall care was fragmented. This was because it lacked co-ordination, leadership and was

not person-centred, where Mr C would be an equal partner in the planning of his care.

96. I accept Adviser 2's advice that Nurse 1 and Nurse 2 failed to comply with professional and clinical standards for practice which would be expected of them as registered nurses and that the Palliative Care Service provided fell below the standards which Mr C and his family should have reasonably expected. This clearly caused stress and uncertainty for Mr C and his family at a very difficult time for them.

97. I would find it concerning in any clinical situation like this if we identified that those charged with caring for a patient showed a lack of empathy and understanding. It is particularly concerning that Adviser 2 identified just such a lack by the nursing staff who were responsible for caring and supporting Mr C, a terminally ill patient, and his family. In addition, Nurse 1 and Nurse 2 had appeared to fail to recognise and acknowledge the impact that the failings identified in their practice had on Mr C and his family.

98. For these reasons, I uphold the complaint.

99. Adviser 2, in their advice to me, has commented on what action could and should be taken to address some of the issues which they have identified with Mr C's nursing care. I have addressed these in my recommendations.

(c) The Board's investigation of and response to Mrs C's complaint was inadequate

Concerns raised by Mrs C

100. Mrs C complained to my office about the Board's handling of her complaint. Mrs C said that although she was supposed to receive a response to her formal complaint within 20 working days, it had taken 45 days. Mrs C was also not satisfied with the Board's response to her complaint, which she felt was incomplete.

The Board's response to Mrs C

101. Mrs C and Ms A initially met with the Board to discuss her concerns relating to Mr C's care and treatment on 1 February 2016. The Board wrote to Mrs C on 11 February 2016 enclosing the note of the discussions which took place at the meeting and asked Mrs C to check this for factual accuracy. The letter also

informed Mrs C that further enquiries were to be made in relation to the concerns she had raised and that a further meeting would be arranged.

102. On 22 February 2015, following receipt of an email from Ms A with amendments to the note of the meeting, the Board wrote to Mrs C enclosing responses received from Doctor 1 and Nurse 1 and asking Mrs C to get in touch if she wished to meet with Doctor 1. On 23 February 2016 the Board emailed Ms A enclosing a copy of their letter to Mrs C and the amended meeting note. On 12 April 2016, Mrs C was offered a meeting with Doctor 1 to take place on 12 May 2016 but declined.

103. On 17 May 2016 the Board received a formal letter of complaint from Mrs C. On 19 May 2016, the Board wrote to Mrs C acknowledging the complaint, setting out what they would look into and explaining that they aimed to provide a response within 20 working days and that they would contact her within that time if they were unable to do so and enclosed a copy of the NHS complaints procedure.

104. The Board acknowledged that there had been errors in earlier correspondence with Mrs C. There was a typographical error in their initial correspondence with Mrs C in relation to the date that Mr C contacted Nurse 1. In relation to an error in the date when Mr C stopped smoking, the Board explained that the February 2015 date did not relate to the date when Mr C stopped smoking but rather that it was recorded at that date he was a former smoker. The Board said they believed this error had occurred when the information was transcribed from Mr C's GP referral correspondence. The Board apologised to Mrs C for these errors and for the confusion they had caused.

The Board's response to SPSO

105. The Board said they were sorry that Mrs C was dissatisfied with how they had investigated and responded to her complaint explaining that they had made a genuine effort to support Mrs C and provide her with answers. Once it was recognised that their responses had not met with her satisfaction, the concerns she had raised were escalated to a formal complaint. When investigating Mrs C's concerns, the appropriate members of staff were involved and an overview was sought from Doctor 2. The Board said while they had hoped that Mrs C would meet with Doctor 1 to discuss her concerns, they respected that she did not wish to do so.

106. The Board went on to say that when they had issued their formal response to Mrs C they had referred to a record of a lung MDT meeting held in June 2015 not being available. The Board said the paperwork relating to this meeting had since been located and a copy was provided to my office.

107. The Board apologised that these documents had not been located during the Board's investigation of Mrs C's complaint which they accepted they should have been. They had identified that this had been caused by Mr C having two sets of case records, as he had attended two hospitals. They had raised what had occurred with the department responsible in dealing with Mrs C's complaint, in order that they consider whether a patient's records may be stored in more than one place. As a result, the Board said they had taken action to address how they stored health records and were introducing a new electronic system during 2017, which will provide a single point for all patient information to be logged electronically.

Nursing advice

108. Adviser 2 considered that the Board had not adequately addressed the issues raised by Mrs C in her complaint in relation to the practice of Nurse 1 and Nurse 2 to ensure that all learning points were addressed to prevent such recurrences in the future.

(c) Decision

109. The Board have acknowledged that there was a typographical error in the original response letter to Mrs C: contact recorded as being made on 30 July 2015 should have read 13 July 2015. They have apologised to Mrs C for this error. With regard to the accuracy of the information in relation to when Mr

C stopped smoking, the Board also acknowledged the error in this information and have apologised to Mrs C.

110. I am satisfied with the action the Board have taken in relation to these matters, but would also ask them to reflect on quality management of responses generally.

111. The Board have acknowledged that their final response to the complaint was not issued within 20 working days of Mrs C's concerns being escalated to a formal complaint. The letter which escalated Mrs C concerns to a formal complaint was received on 17 May 2016. The Board sent an email to Mrs C on 15 June 2016 apologising for not being in a position to issue a response to the complaint within 20 working days. The email explained to Mrs C that the draft response was with their management team for review and it should be possible to provide the response within the next week but if this was not possible she would be informed.

112. The final response was sent on 8 July 2015, which was more than three weeks later. There is no evidence that Mrs C was contacted during this time to explain the reasons for the further delay.

113. The Board, in their response to this office, have accepted that minutes of a MDT meeting should have been available when they responded to Mrs C's complaint. The Board have explained the reasons why this did not happen and the action they have taken to prevent a reoccurrence of this.

114. I have also taken account of the comments of Adviser 2 above concerning the failings in nursing care, which the Board have not acknowledged or addressed in their response to Mrs C's complaint.

115. Overall, I am satisfied there were failings in the Board's handling of Mrs C's complaint so I uphold this complaint and have made recommendations to address these failings.

116. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including

supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b), (c)	<p>There were serious failings in diagnosing that Mr C had lung cancer and in the treatment he received.</p> <p>There were serious failings in the nursing care provided to Mr C after his cancer diagnosis in June 2015.</p> <p>There were failings in the Board's handling of Mrs C's complaint</p>	<p>Apologise to Mrs C for the failings in: Mr C's diagnosis and treatment; the nursing care provided to Mr C after his cancer diagnosis in June 2015; and the handling of Mrs C's complaint.</p> <p>The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spsso.org.uk/leaflets-and-guidance</p>	<p>A copy or record of the apology</p> <p>By: 21 March 2018</p>

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Mr C was unreasonably removed from the expedited lung cancer referral pathway without his case being discussed at a lung MDT meeting, which led to a delay in diagnosing that he had lung cancer. This adversely impacted on Mr C's outcome	Patients who present with suspected lung cancer symptoms should not be removed from the expedited lung cancer referral pathway without the case being discussed at a lung MDT meeting	<p>A copy of the current systems and processes in place on the removal of patients from the cancer referral pathway showing they take into account national guidance and the appropriate process for discussion at a lung MDT meeting.</p> <p>Evidence of the review of patients who were removed from the referral pathway in the same year as Mr C.</p> <p>Evidence that the Board has carried out an independent and impartial review of the lung cancer service which includes considering the appropriateness of any decision to remove a patient from the lung cancer care pathway without an MDT meeting being held. The evidence is to include providing SPSO with a briefing document outlining the scope of the review; who will be carrying out the review; and a report on the outcome of the review.</p> <p>Evidence that this report has been shared with relevant staff and managers in a supportive way for reflection and learning</p>

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
			By: 21 August 2018
(a)	There was a failure to involve Mr C in making an informed decision about his treatment	Patients should be fully informed and involved in decisions about their treatment	Evidence that this report has been shared with relevant staff and managers in a supportive way for reflection and learning By: 23 April 2018
(a)	There was a failure to refer Mr C to a lung MDT meeting when cancer was diagnosed and it became apparent that the skin lesion was metastatic	Patients should be appropriately referred to a MDT meeting	Evidence that patients are being appropriately referred for discussion at MDT meetings within the lung cancer service (this could be evidence provided as part of the audit referred to above) By: 23 April 2018
(b)	Mr C and his family did not receive the standard of palliative nursing care and support which they should have reasonably expected to receive	Patients who require palliative nursing care and their families should the receive care and support needed. This should be adequately led, co-ordinated and person-centred	Details of a review of the Palliative Care Service with evidence that any training needs identified as part of the review are being met, or planned (with definitive timescales, not simply a broad intention). Evidence that this report has been shared with relevant staff and managers in a supportive way and that reflection and learning have taken place

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
			By: 23 April 2018
(b)	There was a failure by nursing staff to comply with national guidance and standards; in particular, in relation to assessing and managing pain and distress; and maintaining care plans	Nursing staff should ensure that national guidance and standards are adhered to; in particular, in relation to the assessment of pain and distress and managing care plans	Evidence that this report has been shared with relevant staff and managers in a supportive way for reflection and learning By: 23 April 2018
(b)	There was a failure to comply with NMC and Scottish Government requirements for prescribing	The Board should ensure that systems are in place to ensure that nurse prescribing complies with NMC standards and Scottish Government guidance	Details of the system in place (including procedures or instructions to staff) to ensure the safe prescribing of medicine by all non-medical prescribers which follows NMC and Scottish Government standards and guidance Evidence that the Board have reviewed whether relevant nursing staff have received sufficient training in the prescribing of medication, particularly to address the failings identified in this report and evidence of how training will be kept up to date By: 23 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	There were omissions in record-keeping in relation to the recording of nursing care provided to Mr C	Nursing records should be maintained in accordance with the nursing and midwifery code of practice and standards	Evidence that the findings of this report have been shared with relevant staff and managers in a supportive way, and what action has been taken as a result By: 23 April 2018
(c)	The Board's handling of Mrs C's complaint fell below a reasonable standard	Staff should be aware of the importance of keeping complainants updated and providing a full response	Evidence that the model CHP has been circulated with attention drawn to matters of particular relevance By: 23 April 2018

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(c)	The Board acknowledged that documents relating to a meeting about Mr C's case had not been located during the Board's investigation of Mrs C's complaint	The Board had raised what had occurred with the department responsible and taken action to address how they stored health records; and they were also introducing a new electronic system during 2017 which will provide a single point for all patient information to be logged electronically	Evidence, such as: discussions about what occurred; the changes that have been made; and revised procedures or instructions to staff about the storage of patient information records By: 23 April 2018

Terms used in the report

Annex 1

Adviser 1	a consultant respiratory physician who provided medical advice on the treatment provided to Mr C
Adviser 2	a nurse who provided nursing advice on the treatment provided to Mr C
asthma	a lung condition which can cause breathing difficulties
computerised tomography (CT) scan	a scan which combines a number of x-rays to produce detailed imaging
dexamethasone	a steroid medication
Doctor 1	a consultant respiratory physician
Doctor 2	the Clinical Director for Emergency Care who reviewed Mr C's care and treatment on behalf of the Board
Doctor 3	a doctor who saw Mr C at an out-patient clinic appointment
gastroesophageal reflux	a condition, where acid from the stomach leaks up into the oesophagus (gullet)
GP	General Practitioner
MDT	multi-disciplinary team
mesothelioma	a type of cancer that develops in the lungs

metastatic	the spread of a cancer to other parts of the body
Mr C	the husband of Mrs C and the subject of this complaint
Mrs C	the complainant
Ms A	Mr and Mrs C's daughter
NMC	Nursing and Midwifery Council
Nurse 1	a community specialist palliative care nurse
Nurse 2	a senior nurse
pleural space	the area between the two layers of the pleura (the thin covering around the lungs) between the lungs and chest cavity
rounded atelectasis	a patch of compressed and deformed lung due to adjacent lung changes
sebaceous cyst	a small lump or bump under the skin
SIGN	Scottish Intercollegiate Guidelines Network guidelines
Sign 106	SIGN guideline 106 - Control of Pain In Adults with Cancer
SIGN 137	SIGN guideline 137 - Management of lung cancer
squamous cancer	a type of skin cancer
the Board	Fife NHS Board

the Hospital

Victoria Hospital, Kirkcaldy

the referral pathway

the Board's expedited cancer referral pathway

the Scottish Palliative Care Guidelines

Scottish Palliative Care Guidelines 2013

List of legislation and policies considered

Annex 2

NICE guideline [CG 121] Lung cancer: diagnosis and management

NMC Code: Professional standards of practice and behaviour for nurses and midwives

NMC Standards of proficiency for nurse and midwife prescribers

Scottish Palliative Care Guidelines 2013

Scottish Government Guidance for Independent Prescribers 2006

SIGN 106 – Control of Pain in Adults with Cancer

SIGN 137 – Management of lung cancer

United Kingdom Lung Cancer Coalition