SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201805020, Tayside NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / diagnosis

Summary
Mrs C complained to me about the care and treatment that her mother (Mrs A) received from Tayside NHS Board (the Board). In May 2017, Mrs A was diagnosed with renal cell carcinoma (a type of kidney cancer) and she was referred for kidney surgery to treat it. Following her kidney surgery in August 2017, Mrs A developed excess fluid around her lungs and an infection; and her condition continued to worsen. In late September 2017, Mrs A was discharged home for end of life care and she died the next day.

Mrs C complained that the Board failed to provide Mrs A with reasonable clinical care and treatment in relation to her kidney surgery. We took independent advice from a consultant urologist (a clinician who treats disorders of the urinary system). We found that the decision to refer Mrs A for kidney surgery was unreasonable. We found there was a low risk the renal cell carcinoma would harm Mrs A; and she was at exceptionally high-risk from kidney surgery.

Mrs C also complained that the Board failed to give Mrs A reasonable care and treatment in response to her worsening condition after her kidney surgery. We found there was an unreasonable delay in recognising Mrs A had a haemothorax (a collection of blood in the lung cavity) but it was then treated appropriately.

Mrs C raised concerns that the Board failed to provide Mrs A with reasonable nursing care. We took independent nursing advice. We found a number of failings in Mrs A's nursing care in relation to the prevention of pressure ulcers (an injury to the skin and underlying tissue, usually caused by prolonged pressure), diabetes management and nutritional care.

Mrs C complained about Mrs A being discharged home for end of life care without appropriate pain relief. We found Mrs A was not prescribed enough hours of pain relief medication; and she should have been given a syringe driver (a machine that delivers continuous pain relief medication), as otherwise a carer would have had to give her hourly injections.

Mrs C raised concerns about the Board's communication with Mrs A and her family about her condition and treatment. The Board acknowledged inadequacies in their communication; and we found that their communication was unreasonable overall. We found that the Board had appropriately apologised to Mrs C for this and we asked them to provide us with evidence of the action they had taken to address this.

We upheld all aspects of Mrs C's complaint. We made a number of recommendations to address the issues identified. 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.

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	What we need to see
(a) (b) (c) and (d)	• The decision to refer Mrs A for kidney surgery was unreasonable and there was a failure to evidence a robust multi-disciplinary team meeting (MDT) outcome and consent process; • There was an unreasonable delay in diagnosing and treating Mrs A's haemothorax; • There were failings in Mrs A's nursing care; and • Mrs A was discharged home without appropriate pain relief	Apologise to Mrs A's family for the failings in her medical and nursing care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology. By: 19 March 2020

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	The decision to refer Mrs A for kidney surgery was unreasonable	In similar circumstances, full consideration should be given to non-surgical treatment options for patients with renal cell carcinoma, in accordance with the relevant guidance	Evidence that these findings have been fed back to the relevant staff and managers in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 20 April 2020
(a)	The urology MDT outcome; and the discussion and/or record-keeping was inadequate	• All potential treatment options should be discussed by urology MDTs and then clearly recorded to facilitate proper engagement with the patient. • Urology MDTs should provide and record an expert opinion on patient management and treatment	Evidence that the Board's urology MDT approach ensures MDT meetings are appropriately recorded and an expert opinion on management and treatment is given. By: 20 April 2020

Complaint number	What we found	Outcome needed	What we need to see
(a)	The consent process for Mrs A's kidney surgery was unreasonable. There was a failure to discuss and record the risks of Mrs A not having kidney surgery, as well as the non-surgical treatment options	Patients should be fully advised of: • the risks relating to both having and not having surgery, and • any non-surgical treatment options. Those discussions should then be clearly recorded as part of the consent process	Evidence that this has been fed back to relevant medical staff in a supportive manner that encourages learning. The SPSO thematic report on informed consent may assist in encouraging learning for staff in this area: http://www.valuingcomplaints.org.uk/spso-thematic-reports By: 20 April 2020
(b)	There were unreasonable failings in diagnosing and treating Mrs A's haemothorax	Patients should be given timely comprehensive assessments and an appropriate diagnosis	Evidence that this case has been used as a learning tool for relevant medical staff, in a supportive way that encourages learning, to help ensure that an appropriate and timely diagnosis is reached in cases such as this By: 19 May 2020

Complaint number	What we found	Outcome needed	What we need to see
(c)	There were a number of failings in the nursing care provided to Mrs A in relation to pressure ulcer prevention	Patients should receive nursing care to prevent and manage pressure ulcers in line with relevant standards and the Board's own guidance	Evidence that the Board have reviewed the training needs of nursing staff in relation to the diagnosis, grading, prevention and management of pressure ulcers. By: 19 May 2020
(c)	There were a number of failings in the nursing care provided to Mrs A in relation to managing her diabetes	Patients should receive nursing care in relation to managing their diabetes in line with relevant standards and the Board's own guidance	A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned. By: 19 May 2020
(c)	There were a number of failings in the nursing care provided to Mrs A in relation to nutritional care	Patients should receive adequate nutritional assessment and care planning in accordance with relevant standards	A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned. By: 19 May 2020

Complaint number	What we found	Outcome needed	What we need to see
(d)	Mrs A was discharged home for end of life care with insufficient pain relief medication	Patients discharged home for end of life care should be given sufficient and appropriate pain relief medication with clear instructions on how it is to be administered and by whom	• Evidence that appropriate guidance/protocols are in place for palliative pain relief; and • Evidence that the findings on this complaint have been fed back to relevant medical staff in a supportive manner that encourages learning. By: 20 April 2020

We are asking the Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a) (b) (c) and (d)	The Board's own complaints investigation did not identify or address all of the failings in Mrs A's medical and nursing care	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement	Evidence that the Board have reviewed why its own investigation into the complaint did not identify or acknowledge all the failings highlighted here and what learning they identified and what changes (if any) they will make. By: 19 May 2020

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	Outcome needed	What we need to see
(c)	The Board acknowledged there were times when Mrs A's bed table was left out of reach	The Board said they had discussed the need to ensure that bed tables are left within easy reach of patients with relevant nursing staff	Evidence that this was discussed with relevant nursing staff and whether any changes will be made as a result. By: 20 April 2020
(e)	The Board acknowledged their communication with Mrs A's family about her condition and treatment was unreasonable	The Board confirmed that they had shared learning with relevant staff	Evidence that the learning was shared with relevant staff. By: 20 April 2020

Feedback

Points to note

Based on the advice I accepted, I am sharing the following which I encourage the Board to consider and reflect on their practice in light of them:

- Many surgeons who are performing complex surgery, especially high-risk surgery, will phone the patient's family immediately afterwards to explain how it went. The Board might wish to consider doing this in future.
- It would have been beneficial if Mrs A had remained under the care of one senior member of medical staff, even when she was transferred within the hospital.
- If possible, one member of medical staff should have been responsible for updating Mrs A's family on her condition and treatment.
- To facilitate good communication, it might be helpful for the Board to develop guidance on what should be communicated to families; how it should be communicated; and how to record this.
- It might be helpful for the Board to develop a communication record, as it would enable all communication to be logged. This could include sections to record the following information: the time; the date; the name of the person; and what information was communicated.

Response to SPSO investigation

- I issued this report to the Board as a draft and invited them to provide comments within 20 working days. The Board requested an extension to respond, which was granted. However, they did not provide their comments within the extended timescale. I am deeply concerned about this delay at this stage in my investigation, especially given the amount of input the Board had already had, and their detailed knowledge of the issues under investigation. I am also concerned about the impact this delay had on Mrs C and her family. The Board have provided me with reasons for this delay and have apologised for it, but I would ask them to reflect on the experience of the complainant and the impact of the delay.
- The Board provided my office with additional records relating to the urology MDT when responding to the draft report. While this does not amount to a shortcoming that requires a recommendation on this occasion, I strongly urge the Board to reflect on how they ensure they provide the SPSO with all relevant information as part of our initial enquiry, and whether that information was appropriately taken into account in their own stage 2 investigation. Where I see repeat failings of this nature, I may choose to take remedial action through my complaints standards powers.

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. 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 me about the care and treatment her late mother (Mrs A) received from the Board, after Mrs A was diagnosed with renal cell carcinoma (a type of kidney cancer).

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

(a) The Board failed to give Mrs A reasonable care and treatment in relation to her August 2017 surgery (*upheld*);

(b) Following her surgery in August 2017, the Board failed to give Mrs A reasonable care and treatment in response to her worsening condition (*upheld*);

(c) Following her surgery in August 2017, the Board failed to give Mrs A reasonable nursing care (*upheld*);

(d) Mrs A was discharged home on 28 September 2017 without appropriate pain relief (*upheld*); and

(e) In August and September 2017, the Board failed to communicate reasonably with Mrs A and her family about her condition and treatment (*upheld*).

3. This report is likely to be extremely difficult for Mrs C and her family to read. I recognise the very difficult time and circumstances they have experienced and they have my, and my complaints reviewer's sincere sympathy.

Investigation

4. I and my complaints reviewer considered all the information provided by Mrs C and the Board. This included Mrs A's relevant medical records and the Board's complaints file. We also obtained independent advice from a consultant urological surgeon (Adviser 1), a nurse (Adviser 2) and a consultant respiratory physician (Adviser 3) on the clinical aspects of the complaint.

5. I have decided to issue a public report on Mrs C's complaint. This reflects my deep concerns about the serious failings identified in Mrs A's care and treatment; and the significant personal injustice to both Mrs A and her family.

6. When responding to Mrs C's complaint, the Board acknowledged there were failings in how they communicated with Mrs A's family about her condition and treatment. However, my investigation has identified a number of other significant

failings, which the Board did not identify when they investigated Mrs C's complaint. I consider the Board's failure to do so and to learn from the concerns raised by Mrs C represents an additional failing in Mrs A's care. By publishing this report, I am aiming to ensure that there is appropriate learning and lasting improvement from the failings identified by my investigation.

7. 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. Comments received were taken into account in the writing of the report.

Background

8. In May 2017, Mrs A had a scan for her heart condition. It showed a small lesion on her right kidney. In early July 2017, Mrs A was referred to a urology multi-disciplinary team meeting (MDT) to discuss her diagnosis and treatment options. Mrs A's kidney lesion was considered to be renal cell carcinoma.

9. Following the urology MDT, Mrs A had an appointment with a consultant urological surgeon. She was referred for kidney surgery, specifically a right radical nephrectomy (the surgical removal of the right kidney). A week later, Mrs A was reviewed by a consultant cardiologist who provided her with advice on optimising her heart and anti-blood clotting medication in advance of the kidney surgery. Mrs A also attended a surgical pre-assessment clinic, where she was reviewed by a consultant anaesthetist.

10. In mid-August 2017, Mrs A had kidney surgery at Ninewells Hospital (the hospital) and she did not appear to suffer any complications. Mrs A was taken to the surgical high dependency unit to recover. A biopsy (tissue sample) from Mrs A's right kidney was sent for testing and it confirmed the kidney lesion was renal cell carcinoma. Mrs A was briefly transferred to a ward; she was then transferred to the coronary care unit, as she was experiencing chest pain.

11. In late August 2017, Mrs A was considered to have an effusion, which is excess fluid around the lung. She was given antibiotics and medical staff unsuccessfully tried to drain the excess fluid with chest drains. Mrs A was referred for a CT scan, which showed she had a haemothorax. She was treated with a larger chest drain. The drained fluid tested positive for an infection and Mrs A was given antibiotic treatment. During this time, Mrs A was transferred between the coronary care unit and the respiratory unit three times.

12. By early September 2017, Mrs A's condition was not improving. An x-ray showed she still had fluid around her lung and she was treated with another chest drain. Medical staff sought advice from the cardiothoracic team (specialists in treating disorders of the chest, heart and lungs) in Edinburgh. Mrs A was transferred to Edinburgh where she underwent video-assisted thoracic surgery (VATS). Afterwards, Mrs A experienced a problem with her heart, specifically a ventricular fibrillation (a problem with the heart's electrical signals that causes it to stop pumping).

13. Later in September 2017, Mrs A was transferred back to the hospital. Unfortunately, her condition continued to worsen. Mrs A was considered to have developed pulmonary oedema (a condition caused by excess fluid in the lungs that can cause breathing difficulties). Mrs A did not wish to have further treatments or investigations. At the end of September 2017, Mrs A was discharged home for end of life care. Sadly, she died at home the next day.

(a) The Board failed to give Mrs A reasonable care and treatment in relation to her August 2017 surgery

Concerns raised by Mrs C

14. Mrs C said Mrs A was told that kidney surgery was the only available treatment option for her renal cell carcinoma. Mrs C questioned if kidney surgery was appropriate for Mrs A. Mrs C explained their family was told that Mrs A had internal bleeding after her kidney surgery. Mrs C said they were given different information about what had caused this; and whether something had gone wrong during the kidney surgery, such as a nicked artery.

The Board's response

15. The Board said that they considered kidney surgery to be the best treatment option for Mrs A. They said the kidney surgery was discussed with Mrs A and her husband, to ensure she was fully informed. The Board said Mrs A was advised that the kidney surgery would carry significant risk due to her heart condition. They told us that Mrs A was given a leaflet (produced by the British Association of Urological Surgeons), which contained information about alternative treatment options to surgery. The Board explained that a consultant cardiologist had reviewed Mrs A, to advise her on how to optimise her heart medications, in advance of the kidney surgery.

16. The Board explained that nothing untoward happened during Mrs A's kidney surgery. They said she experienced minimal blood loss and there was no evidence of bleeding when her surgical wounds were closed. The Board told us that Mrs A's

blood levels were checked three times after her kidney surgery and they did not drop. They said that if an artery had been nicked, this would have been apparent within 24 hours of the kidney surgery.

Medical advice: relevant clinical guidelines

17. Adviser 1 (consultant urologist) said there were various recognised clinical guidelines, which were relevant to their consideration of this complaint. Adviser 1 explained that the European and American guidelines are exclusively used to guide clinical practice in the UK. Adviser 1 also referred to relevant quality performance indicators in relation to urology MDTs. In particular, Adviser 1 referred to:

- *Renal Cell Carcinoma* the European Association of Urology (EAU) guidelines (updated 2017);
- *Renal Cancer Guideline* the American Urological Association (AUA) guidelines (April 2017); and
- *Renal Cancer Quality Performance Indicators* (QPIs) NHS Scotland (2016).

18. Adviser 1 said the EAU guidelines discuss studies on the outcomes for patients with renal cell carcinoma. They explain that patients treated with surgery have a significantly lower mortality rate from renal cell carcinoma. However, an analysis of elderly patients (like Mrs A) failed to show the same benefits from surgery for renal cell carcinoma. The studies report that elderly patients and those with pre-existing health conditions, with small kidney lesions (4 centimetres or smaller) have a low mortality rate from renal cell carcinoma and a high mortality rate from other causes. The EAU guidelines discuss 'active surveillance' as a non-surgical treatment option; which involves monitoring the size of a kidney lesion with imaging. If a kidney lesion increases in size, surgery can be considered at that point; this is called 'delayed intervention'.

19. Adviser 1 explained that the AUA guidelines also discuss studies on patients with small kidney lesions (as in Mrs A's case), who were treated with the approach of active surveillance. They explain that in the initial three years of active surveillance, there appears to be a less than 2% risk of renal cell carcinoma spreading in well-selected patients. They go on to say that longer-term studies (longer than three years) will be helpful in clarifying what patients are most suitable for active surveillance.

20. Adviser 1 said that the kidney cancer QPIs, as referred to above, highlight the benefit of urology MDTs for people with renal cell carcinoma. They say that a

urology MDT should provide an expert opinion on managing and treating people with renal cell carcinoma.

Medical advice: Mrs A's heart problems

21. Adviser 1 explained that Mrs A had a history of significant heart problems. They noted that in 2016, she had a non-STEMI heart attack (a partial blockage of the blood that supplies the heart). Adviser 1 said the function of Mrs A's left ventricle (the lower left portion of the heart) was quite significantly impaired. As a result, she was fitted with two stents into her left coronary artery (the artery that supplies blood to the left side of the heart). Adviser 1 also said that Mrs A's left anterior descending artery (an artery that branches off from the left coronary artery) had blocked. Adviser 1 explained that after her heart attack, Mrs A had problems with angina. In addition, she had a scan that confirmed her ejection fraction (the amount of blood pumped out of the heart with each beat) was 40%, which was low. Adviser 1 explained that in early 2017, cardiology were considering referring Mrs A for a procedure to reopen her left anterior descending artery with a stent.

Medical advice: referral to urology MDT

22. Adviser 1 noted that in Mrs A's MRI scan in May 2017, a small (4 centimetre) lesion was found in her right kidney. Adviser 1 said that a CT scan was then carried out, which was appropriate and it confirmed this finding. Adviser 1 explained there was no evidence that the cancer had spread elsewhere in Mrs A's body. Adviser 1 noted that Mrs A was urgently referred to the urology MDT.

23. Adviser 1 said the MDT attendance list confirmed there was a broad expertise of input from urology and oncology (cancer specialists). As a result, Adviser 1 considered the MDT process was adequate. Adviser 1 noted that in the urology MDT discussion, they outlined Mrs A's medical history. They also noted Mrs A's history of heart problems and her ongoing chest discomfort. Adviser 1 explained there was no record of Mrs A's TNM, which is a standard measure for the extent of cancer (i.e. the tumour, node, metastasis). However, Adviser 1 said it was noted there was no evidence Mrs A's cancer had metastasised (spread elsewhere in the body).

24. Adviser 1 said that despite the assembled expertise at the urology MDT, there was no clear record of a discussion about the potential treatment options for Mrs A's small kidney lesion. For example, there was no note of a discussion about the options of active surveillance and delayed intervention. Also, Adviser 1 noted that the recorded outcome of the urology MDT was for Mrs A to be seen in a specialist clinic. Adviser 1 described that as an inadequate outcome of a urology MDT, particularly given Mrs A's history of heart problems. They said the urology MDT

should have given and recorded an expert opinion on managing and treating Mrs A's condition, particularly given her medical history.

25. Adviser 1 noted that following the urology MDT, Mrs A attended a urology appointment and she was referred for kidney surgery.

Medical advice: referral for kidney surgery

26. Adviser 1 explained that kidney surgery aims to cure renal cell carcinoma; and it is the best treatment for patients medically fit for surgery. However, Adviser 1 considered the decision to refer Mrs A for kidney surgery was unreasonable. Adviser 1 explained that, as discussed in the EAU and AUA guidelines above, Mrs A's small renal cell carcinoma might not have caused her any harm. Adviser 1 said that Mrs A was at exceptionally high-risk from kidney surgery because she was elderly and she had significant heart problems. Adviser 1 explained that if Mrs A suffered any significant complication from the kidney surgery, it was likely to set off a cascade of medical problems that might not be reversible.

27. Having reviewed the relevant medical records, Adviser 1 considered there was evidence that the complications of kidney surgery were clearly outlined to Mrs A and that she was told about the high risk involved. However, Adviser 1 explained there was no evidence that the risks of *not* [my emphasis] having kidney surgery were clearly outlined to her in that discussion. The Board explained that Mrs A was given information leaflets, which contained information about alternative treatment options including active surveillance and delayed intervention. Yet, Adviser 1 explained there was no record that these non-surgical treatment options were discussed with Mrs A or her family. Adviser 1 considered this was unreasonable.

28. Adviser 1 noted that prior to her kidney surgery, Mrs A was reviewed by a consultant cardiologist. Adviser 1 further noted the consultant cardiologist gave Mrs A advice on trying to optimise her heart medications. Mrs A then attended a pre-surgical assessment with a consultant anaesthetist. Adviser 1 said Mrs A was still experiencing symptoms from angina when she attended her pre-surgical assessment.

Medical advice: complications during the kidney surgery

29. Adviser 1 explained they had reviewed the operation note and the anaesthetic monitoring note of Mrs A's kidney surgery. They said there was no evidence of any specific complication arising during the kidney surgery or afterwards. Adviser 1 said the operation note mentioned Mrs A had minor bleeding from a vein (specifically the right adrenal vein – a blood vessel that drains blood from the kidney). This was

controlled by a harmonic scalpel (an instrument that uses an energy source to seal a blood vessel). Adviser 1 explained that this vein is situated next to the diaphragm. Adviser 1 said it was possible there was a small accidental injury to Mrs A's diaphragm. They explained that if that occurred, Mrs A's anti-blood clotting medication could have caused her to later develop a haemothorax. However, Adviser 1 emphasised this was only a *possibility* and there was insufficient evidence to establish what caused the haemothorax.

30. Adviser 1 noted Mrs C's concern that an artery might have been nicked during Mrs A's kidney surgery but went on to explain there was no evidence that Mrs A experienced any serious internal bleeding during the kidney surgery or immediately afterwards. Adviser 1 said that if an artery had been nicked, Mrs A would have developed signs of hypotension, tachycardia (raised heart rate) and poor urinary output earlier. Adviser 1 said Mrs A's initial observations were normal, including her haemoglobin levels.

31. Adviser 1 explained that Mrs A had an episode of hypotension the day after her kidney surgery. This was attributed to her heart medication and Adviser 1 considered that was reasonable. Adviser 1 told us that Mrs A's medical management during her kidney surgery and in the immediate 24 hours afterwards was appropriate. However, Adviser 1 confirmed that the kidney surgery did subsequently lead to a cascade of medical complications, and they resulted in Mrs A's death.

(a) Decision

32. The basis on which I reach conclusions and make decisions is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. I do not apply hindsight when determining a complaint.

33. The advice I have received, and I accept from Adviser 1 is that the decision to refer Mrs A for kidney surgery was unreasonable. I was advised that:

- Mrs A had a small kidney lesion that was consistent with renal cell carcinoma. However, there was a low risk that it would cause Mrs A harm;
- Mrs A had a history of significant heart problems, which along with her age, meant she was at exceptionally high-risk from kidney surgery;
- The urology MDT attendance was adequate, as appropriate medical specialists were in attendance;
- The urology MDT discussed Mrs A's medical history, pre-existing health conditions and the extent of her renal cell carcinoma. However, there was no

clear note of all of the potential treatment options including active surveillance and delayed intervention;

- The recorded outcome of the urology MDT's discussion was that Mrs A should be seen in a specialist clinic, which was inadequate. The urology MDT should have given and recorded an expert opinion on managing and treating Mrs A's condition, particularly given her medical history;
- Active surveillance, and delayed intervention if her kidney lesion had increased in size, would have been more appropriate for Mrs A, given her age and significant heart problems;
- The medical records evidence that the risks of kidney surgery were discussed with Mrs A. She was also given written information about non-surgical treatment options, including active surveillance and delayed intervention;
- There was no record of any discussion with Mrs A about the non-surgical treatment options. There was also no record Mrs A was told about her low risk of harm from the renal cell carcinoma; and
- Unfortunately, the kidney surgery led to Mrs A's developing medical complications and these resulted in her death.

34. The advice I have also received and I accept from Adviser 1 is that there was no evidence that something went wrong during Mrs A's kidney surgery. For example, there was no evidence that an artery was nicked or that she had serious internal bleeding during or immediately afterwards. While it was possible that Mrs A's diaphragm was accidently injured during the kidney surgery, which could have caused her to later develop a haemothorax, I note Adviser 1 emphasised that there was insufficient evidence to establish what caused it. Adviser 1 considered Mrs A's care and treatment within the initial 24 hours of her kidney surgery was reasonable.

35. In light of the above, I consider the decision to refer Mrs A for kidney surgery was unreasonable. I am critical of the MDT process. An MDT meeting is a well-established and recognised mechanism to ensure good quality patient care. As such, there should be appropriate discussion and consideration of the patient, including treatment options. Discussion, options and outcomes should be properly documented. I am unable to say with any certainty from the documentation in this case that there was an adequate discussion and consideration of the treatment options for Mrs A by the MDT. I am extremely critical of the lack of information in the documentation in this respect. The advice I have received and accept is that the outcome of the MDT meeting, to refer Mrs A to a specialist clinic, was unreasonable, particularly given her history of serious heart problems and the lack of clearly recorded outcomes. I consider this was unreasonable care.

36. I also consider the consent process for Mrs A's kidney surgery was inadequate, as there was no evidence that she was clearly informed about the risks of *not* having kidney surgery. There was simply no evidence that alternative treatment options were discussed with her. It was inappropriate and unreasonable for the Board not to have had these discussions with Mrs A and clearly recorded them. I am deeply concerned that the Board have not recognised the importance of respecting a patient's right to be fully informed and involved in making decisions about their own care and treatment.

37. In light of the failings identified, I uphold this complaint. My recommendations for action by the Board are set out at the end of this report.

(b) Following her surgery in August 2017, the Board failed to give Mrs A reasonable care and treatment in response to her worsening condition

Concerns raised by Mrs C

38. Mrs C said Mrs A deteriorated rapidly in the weeks after her kidney surgery. She considered there was a delay in taking action to address her internal bleeding. Mrs C felt the medical staff seemed, instead, to focus on treating Mrs A for an infection. Mrs C explained that when Mrs A was later transferred to Edinburgh, they were told she did not have an infection.

The Board's response

39. In their response to us, the Board acknowledged there were missed opportunities to obtain a timely chest x-ray and CT scan, which would have led to an earlier diagnosis of Mrs A's haemothorax (a collection blood in the lung cavity). They also acknowledged a lack of routine blood monitoring during that time. However, the Board considered Mrs A's treatment for her haemothorax and infection was reasonable. They said they undertook appropriate interventions, while taking into account the risks associated with those interventions.

Medical advice from Adviser 1: diagnosing the haemothorax

40. Adviser 1 explained that initially, Mrs A was considered to have a simple effusion (excess fluid around the lung). However, it was later discovered that she had a haemothorax. Adviser 1 explained that a haemothorax would have been an uncommon post-surgery complication. Nevertheless, Adviser 1 considered there was an unreasonable delay in diagnosing and treating it, for the reasons I outline below.

41. Adviser 1 noted that on 17 August 2017, Mrs A's haemoglobin level had dropped to 10.6 grams per decilitre (g/dl). Adviser 1 explained that on 19 August

2017, Mrs A had a chest x-ray and it did not show evidence of an effusion or haemothorax. Adviser 1 did not find evidence that any blood tests were carried out between 19 August 2017 and 23 August 2017. Adviser 1 described this as highly unusual, particularly as Mrs A had an acute kidney injury and there had been a noted drop in her haemoglobin level. Adviser 1 said Mrs A should have received daily blood tests during that period. Adviser 1 considered this would have alerted medical staff to Mrs A having experienced internal bleeding at an earlier point.

42. Adviser 1 said that on 21 August 2017, Mrs A was noted to be breathless. The following day, Mrs A reported having some chest pain. Adviser 1 noted that Mrs A was given blood tests. They showed a further significant drop in Mrs A's haemoglobin level, as it was noted to be 7.4 g/dl. On 23 August 2017, Mrs A had clinical signs of reduced air entering her right lung. Adviser 1 said in these circumstances, medical staff should have recognised Mrs A had experienced internal bleeding but they did not. Adviser 1 considered that if they had, Mrs A should have been urgently referred for a CT scan to investigate her condition further. Adviser 1 explained that a CT scan with contrast might not have been appropriate for Mrs A at that time. This is because contrast can be toxic and she had a kidney injury. However, Adviser 1 said that a plain CT scan would also have shown evidence of internal bleeding and in Mr A's case, it would have shown evidence she had a haemothorax.

43. Adviser 1 explained that on 25 August 2017, Mrs A was referred for a chest x-ray. It showed a white-out of her right lung. Adviser 1 said it was noted in the medical records that this could be evidence of an infection or possibly cancer. Adviser 1 considered the medical staff should have recognised it was likely to be blood, as it was on the same side of the body as Mrs A's kidney surgery and her haemoglobin level had fallen.

44. Adviser 1 noted that Mrs A was referred for an ultrasound scan (a scan that uses sound waves to create images of organs and structures inside the body). She was then referred to the respiratory team for a review.

Medical advice from Adviser 3: diagnosing the haemothorax

45. We shared the above urology advice with Mrs C and the Board as a draft report; and we invited them to make any comments in response. Due to the information provided by the Board, we decided to obtain advice from a consultant respiratory physician (Adviser 3). In particular, the Board explained they considered the use of smaller chest drains was appropriate and that it was reasonable to consider if cancer spread had caused Mrs A's bleeding.

46. Adviser 3 confirmed that the medical evidence was consistent with Mrs A experiencing a haemothorax on 22 August 2017. Adviser 3 agreed with Adviser 1 that there was an unreasonable delay in medical staff diagnosing this. Adviser 3 acknowledged that a haemothorax is uncommon; that Mrs A had an unremarkable chest examination on 22 August 2017; and that a range of diagnoses could have caused her bleeding. In particular, Adviser 3 explained that if kidney cancer spreads to the lung area, it can result in bleeding. However, Adviser 3 considered Mrs A had several factors that increased the risk of haemothorax, including her age and her anti-blood clotting medication. Adviser 3 considered that when Mrs A was found to have abnormal chest signs on 23 August 2017, a more comprehensive assessment should have been carried out of her condition. Adviser 3 noted Adviser 1 considered a CT scan should have been carried out and explained that a chest x-ray would also have shown an effusion, which could have been confirmed with an ultrasound. However, Adviser 3 noted that a chest x-ray was not carried out until 25 August 2017. Adviser 3 considered this amounted to an unreasonable delay in carrying out a comprehensive assessment of Mrs A's condition.

Medical advice from Adviser 1: chest drains

47. Adviser 1 explained that on 26 August 2017, the respiratory team inserted a chest drain to drain what they believed to be an effusion. Adviser 1 said there was blood from the chest drain, which the respiratory team would not have been expecting. Adviser 1 explained that on 30 August 2017, Mrs A's first chest drain was removed. That same day, the respiratory team tried to insert another chest drain but it was unsuccessful. Adviser 1 noted that both times, the respiratory team had used a chest drain that was size 16f. Adviser 1 considered that size of chest drain was inadequate for treating a haemothorax, as the recommended size would be 28-30f. Adviser 1 further considered that as a result, the fluid was not adequately drained.

48. On 31 August 2017, Mrs A was given a chest CT scan with contrast. Adviser 1 explained this was considered appropriate because there was a noted improvement in Mrs A's estimated glomerular filtration rate (EGFR- a key indicator of kidney function). On that same day, medical staff treated Mrs A with a larger chest drain (size 24f). Adviser 1 explained that this larger size of chest drain might have been an adequate size to treat Mrs A's haemothorax, even though it is smaller than the recommended size of 28-30f, as stated above. However, Adviser 1 explained that the chest drain became blocked and on 3 September 2017, they removed it. Adviser 1 said that on 5 September 2017, Mrs A had a chest x-ray that still showed fluid in her lung cavity. So medical staff then attempted to treat Mrs A with a third chest drain (also size 24f).

49. Adviser 1 explained that on multiple occasions, the fluid from Mrs A's right lung cavity was tested and found to be infected. Adviser 1 confirmed that Mrs A received appropriate treatment for her infection with antibiotics. Adviser 1 considered it was likely that the need to use multiple chest drains had caused Mrs A to develop this infection.

50. Adviser 1 said Mrs A's infection, and the failure to resolve her haemothorax, resulted in her transfer to Edinburgh for VATS. Adviser 1 considered that although the decision to transfer Mrs A for VATS was reasonable, if Mrs A's haemothorax had been diagnosed earlier than 26 August 2017, and if it had been treated with a large chest drain from the outset, then her haemothorax might have been resolved and she might not have needed VATS.

Medical advice from Adviser 3: chest drains

51. Adviser 3 noted the medical staff took a conservative approach to treating A's haemothorax with chest drains and antibiotics. Adviser 3 confirmed it was appropriate they took that approach and tried to avoid the need for surgical intervention, given Mrs A's age and heart condition. In relation to the size of the chest drains used, Adviser 3 commented that many clinicians would endorse the use of a larger chest drain for treating a haemothorax, as they should be less likely to clot and be better for assessing continuing blood loss. However, Adviser 3 explained that smaller chest drains are more comfortable for patients and they can be effective, particularly in the early stages of treating a haemothorax. Adviser 3 stated that it was appropriate that medical staff used a larger chest drain to treat Mrs A on 31 August 2017, as it was noted that the fluid had thickened.

(b) Decision

52. The advice I received and I accept from Adviser 1 and Adviser 3 is that there was an unreasonable delay in recognising Mrs A had a haemothorax. In particular, I was advised that:

- There was a three-day gap following Mrs A's kidney surgery, where no blood tests were carried out. This was unreasonable, as Mrs A had an acute kidney injury and there had been a noted drop in her haemoglobin level;
- If daily blood tests had been carried out, it was likely that medical staff would have realised that Mrs A had experienced internal bleeding sooner;
- When Mrs A's blood tests showed her haemoglobin level had fallen further and she was found to have abnormal chest signs, she should have been urgently referred for further investigations to assess her condition. A CT scan (or a chest x-ray followed up by an ultrasound) would have shown evidence of her

haemothorax at that time. Mrs A was given a chest x-ray two days later, which was an unreasonable delay in comprehensively assessing her condition; and

- If Mrs A's haemothorax had been diagnosed earlier it *might* have prevented the need for further chest drains and her transfer for VATS.

53. The advice I received and I accept is that Mrs A's haemothorax was treated appropriately. In particular:

- Adviser 1 confirmed that Mrs A's infection was treated appropriately and with the correct antibiotics;
- Advisers 1 and 3 considered a larger size chest drain could have been used to treat Mrs A's haemothorax. Adviser 3 confirmed many clinicians would endorse the use of a larger chest drain. Adviser 3 explained there is also evidence to support the use of smaller chest drains, particularly in the early stages of treating a haemothorax, as they can also be effective and they are more comfortable for the patient; and
- Adviser 3 considered it was reasonable medical staff took a conservative approach to treating Mrs A's haemothorax; and that she was transferred to Edinburgh for VATS, when the antibiotics and chest drains had not improved her condition. Given this I am unable to conclude that the size of chest drain used to treat Mrs A was unreasonable and I consider that the overall approach to treating Mrs A's haemothorax conservatively was reasonable.

54. In light of the failings identified in diagnosing Mrs A's haemothorax, I uphold this complaint. Unfortunately, my investigation has been unable to allay Mrs C's concerns about the care and treatment Mrs A received after her kidney surgery. I understand she was in a great deal of discomfort and this must have been very upsetting for her family to witness. It must also be very upsetting for them to read my conclusions and they have my fullest sympathy.

55. I have made a number of recommendations in view of my findings, which can be found at the end of this report. All of my recommendations for action to address the failings identified will be followed up to ensure implementation, which I hope will be of some comfort to Mrs A's family.

(c) Following her surgery in August 2017, the Board failed to give Mrs A reasonable nursing care

Concerns raised by Mrs C

56. Mrs C raised concern that Mrs A did not receive appropriate skin care in the hospital. She explained Mrs A developed a pressure ulcer, which caused her significant pain and discomfort. Mrs C complained that by the time Mrs A was transferred to Edinburgh for VATS, her pressure ulcer was severe.

57. Mrs C also raised concern that Mrs A's diabetes was not managed appropriately. She explained that on two occasions, Mrs A was transferred within the hospital and her insulin was left behind. Mrs C explained that Mrs A had two diabetic comas. Mrs C said she later noticed the nursing staff were giving Mrs A too much insulin, as she was hardly eating.

58. Mrs C complained that no real effort was made to give Mrs A basic nutrition or hydration. She said Mrs A lost a lot of weight, becoming weaker as she did so. Mrs C explained that Mrs A's bed table was often left out of reach so she was unable to reach things.

The Board's response

59. In their response to us, the Board accepted there were failings in the nursing care provided to Mrs A in relation to ulcer prevention, managing her diabetes and nutritional care. The Board said they would be updating and developing improvement plans to address this. The Board apologised that Mrs A's bed table was left out of reach; and said they had discussed this issue with relevant nursing staff.

Medical advice: pressure ulcer prevention

60. Adviser 2 (nursing) explained there was Scottish guidance on nursing care, which was relevant to their consideration of this complaint. In particular, Adviser 2 referred me to:

- *Care of Older People in Hospital Standards* Health Improvement Scotland (2015);
- *CPR for Feet* Scottish Diabetes – Foot Action Group (2015);
- *Guidelines for the Use of the CME T34 Syringe Pump for Adults in Palliative Care* Health Improvement Scotland (2011);
- *Scottish Wound Assessment and Action Guide* Health Improvement Scotland (2010);
- *Standards for Food, Fluid and Nutritional Care* Health Improvement Scotland (2014); and

- *Prevention and Management of Pressure Ulcer Standard* Health Improvement Scotland (2016).

Adviser 2 also referred to the Board's own guidance in relation to insulin administration; blood glucose control in the surgical high dependency unit (SHDU); and pressure ulcer prevention and treatment, as follows:

- *Diabetic Guideline - Glucose Control in* SHDU NHS Tayside
- *Patient Partnership for Insulin Administration* NHS Tayside
- *Pressure Ulcer Prevention Treatment Plan* NHS Tayside

Medical advice: pressure ulcer prevention

61. Adviser 2 said Mrs A did not receive appropriate care to prevent pressure ulcers, which resulted in her developing avoidable pressure damage. Adviser 2 explained that a waterlow risk assessment chart is used to assess the risk of a patient developing pressure ulcers. Adviser 2 said there was a requirement to complete this within six hours of Mrs A's hospital admission; and it should have been repeated weekly when her condition worsened. Adviser 2 said Mrs A's initial waterlow risk assessment chart was not completed fully; and there was then a failure to repeat it.

62. Adviser 2 noted Mrs A was considered to be at risk of developing pressure damage. It was recorded that every two hours, Mrs A should have a pressure relieving check and a skin inspection to check for pressure damage. Adviser 2 said that on numerous occasions these two-hourly checks were not carried out. Adviser 2 explained that on several days, Mrs A's skin was only inspected five or six times a day instead of the required twelve times.

63. Adviser 2 noted that in late August 2017, Mrs A was assessed as needing additional support from a pressure redistributing mattress. Adviser 2 explained this was to help protect Mrs A from pressure damage. However, Adviser 2 noted there was a delay in obtaining it for Mrs A. Adviser 2 further noted that when Mrs A was transferred back to the hospital from Edinburgh, there was again a delay in obtaining this type of mattress for her.

64. Adviser 2 explained that in late September 2017, Mrs A was noted to have spongy heels. Adviser 2 said that as set out in the '*CPR for Feet'* guidance, Mrs A should have been referred to podiatry and that did not happen. Adviser 2 explained that Mrs A was at high-risk of foot damage because of her diabetes. Adviser 2 said Mrs A should have been given additional foot protection or a high specification

mattress to help protect her feet against pressure damage. However, Adviser 2 explained this was not provided to her.

65. Adviser 2 noted that Mrs A developed a wound at the base of her spine. Adviser 2 said there was obvious confusion amongst the nursing staff about how to diagnose the wound. Adviser 2 explained that sometimes it was noted to be a moisture lesion; sometimes it was noted to be grade 2 pressure damage; and at one point, it was incorrectly noted to be a grade 2 moisture lesion. Adviser 2 said Mrs A's wound should have had a definitive diagnosis. Adviser 2 told us the nursing staff should have had sufficient training to know how to grade pressure ulcers and how to classify moisture lesions.

66. Adviser 2 stated there were also failings in the completion of Mrs A's wound management assessment chart. Adviser 2 explained that there were gaps in the wound chart and mistakes in the information recorded.

Medical advice: diabetes management

67. Adviser 2 considered Mrs A did not receive reasonable care in relation to managing her diabetes. Adviser 2 explained that Mrs A's diabetes control was managed in different ways. Mrs A injected insulin herself or nursing staff injected her with insulin; and she was given a continuous infusion of insulin (where a device is used to provide insulin). Adviser 2 explained that the Board had issued guidance in relation to both types of diabetic control, as referred to above, but the guidance was not followed in this case, as detailed below.

68. Adviser 2 explained the Board had a monitoring record for insulin and blood glucose levels, which listed performance indicators. It states that the patient's diabetes care must be improved if the answer to any question is 'no'. Adviser 2 noted that one of the questions asked if the patient's blood glucose level was rechecked 15 minutes later if it was noted to be low (below 4 mmol/L). Adviser 2 explained that over a three-day period, from 21 September to 23 September 2017, Mrs A had several episodes of very low blood glucose levels. Adviser 2 noted that from Mrs A's monitoring record, it did not appear her blood glucose levels were checked again 15 minutes later. Adviser 2 explained that according to the monitoring record, this meant her diabetes care required improvement.

69. Adviser 2 referred me to the Board's guidance on insulin injections. Adviser 2 explained the guidance said they would record the insulin a patient had taken along with their blood glucose levels. However, Adviser 2 explained there were gaps in the record-keeping of Mrs A's insulin and blood glucose levels. Adviser 2 noted there

were also issues where Mrs A's insulin was not transferred with her, which was also contrary to this guidance.

70. Adviser 2 further noted the Board's guidance said that a patient's ability to self-administer insulin should be reassessed daily. Adviser 2 explained there were several periods where Mrs A was confused and disorientated but she was still allowed to self-administer her insulin. Adviser 2 considered it was unreasonable that nursing staff did not take over Mrs A's insulin administration during those times.

71. Next, Adviser 2 addressed the Board's guidance in relation to a continuous infusion of insulin, as mentioned above. When using this method of diabetes control, the patient's blood glucose levels should be checked to see if their insulin amount needs to be adjusted. Adviser 2 explained that according to the Board's guidance, Mrs A's blood glucose level should have been checked at least every two hours. Adviser 2 noted that this guidance was not followed between 16 August 2017 and 17 August 2017. In particular, Adviser 2 explained there were four occasions where Mrs A's blood glucose levels were not checked for more than three hours.

Medical advice: nutritional care and weight loss

72. Adviser 2 considered the nutritional care Mrs A received was also unreasonable. Adviser 2 said there was a failure to properly meet her food, fluid and nutritional needs during her admission. Adviser 2 said there was no evidence that a patient-centred nutritional care plan was prepared when Mrs A was admitted to the hospital, which is a requirement for all patients. Adviser 2 considered this contributed to subsequent failings in addressing the issues that were compromising Mrs A's nutritional status.

73. Adviser 2 explained that there was only one weight recorded for Mrs A; it was noted to be 51 kilograms on her admission. This was recorded as part of Mrs A's malnutrition universal screening tool (MUST) assessment, which assesses a patient's nutritional needs. Adviser 2 explained that the MUST assessment should have been repeated weekly and it should have involved monitoring and recording Mrs A's weight. Adviser 2 explained there was no record that Mrs A had weekly MUST assessments and there was no further record of Mrs A's weight during her admission; which was unreasonable. Adviser 2 stated that as a result, they were unable to comment on any weight loss Mrs A had experienced during her admission.

74. Adviser 2 went on to explain that there was a delay in referring Mrs A to a dietician. They said that as early as 22 August 2017, Mrs A was noted to have nausea and a reduced appetite, with low blood glucose levels as a result. Adviser 2

said that at the first sign of Mrs A having a decreased appetite, nursing staff should have developed a person-centred care plan to address her food, fluid and nutritional needs.

75. Adviser 2 explained that Mrs A's diabetes would have been poorly controlled if she was not eating enough and noted it was not until 23 September 2017 that Mrs A was identified as needing input from a dietician. Adviser 2 further explained that there was no record of a referral to a dietician being made. Adviser 2 explained that a food assessment chart should been completed but there was no record of this.

(c) Decision

76. The advice I received and I accept from Adviser 2 is that there were a number of failings in Mrs A's nursing care in relation to pressure ulcer prevention; diabetes management; and nutritional care.

77. In particular, Adviser 2 considered, and I accept that:

- There was a failure to fully complete and repeat a waterlow risk assessment, which assesses a patient's risk of pressure ulcers;
- Mrs A did not always receive the two-hourly checks to prevent pressure damage, which she was assessed to need on her admission;
- There were delays in obtaining a pressure redistributing mattress for Mrs A;
- Mrs A should have been referred to podiatry when she was noted to have spongy heels;
- Mrs A should have received additional foot protection or a high specification mattress to help protect her feet from pressure damage, as she had diabetes;
- There were failings in how Mrs A's pressure ulcer was assessed and diagnosed;
- There were gaps in the record-keeping of Mrs A's insulin administration and blood glucose levels;
- There were unreasonable delays in checking Mrs A's blood glucose levels;
- Nursing staff should have taken over Mrs A's administration of insulin during the times she was unwell and/or cognitively impaired;
- A person-centred nutritional care plan was not prepared for Mrs A;
- There was a failure to carry out weekly MUST assessments and weight checks to assess her nutritional needs and status; and
- There was an unreasonable delay in recognising the need to refer Mrs A to a dietician and then a failure to action the referral.

78. In view of the multiple failings in nursing care, I can only conclude that Mrs A's nursing care was unreasonable. I understand fully the family's concerns that her

basic nursing needs were not met; and that Mrs A was often uncomfortable and in pain as a result. I am particularly concerned that these failings added to Mrs A's and her family's distress, during what was already such a difficult time.

79. I uphold this complaint and I have made recommendations in view of the issues I have highlighted. These are set out at the end of this report

(d) Mrs A was discharged home on 28 September 2017 without appropriate pain relief

Concerns raised by Mrs C

80. Mrs C complained that Mrs A was discharged home from the hospital without appropriate pain relief. She explained that Mrs A was experiencing pain overnight before she died the following day.

The Board's response

81. The Board said that when Mrs A was discharged home, they did not have a standardised discharge protocol in place for palliative patients. However, the Board explained they have since developed and implemented one. The Board noted that Mrs A was discharged home with injectable morphine for pain relief. They explained that the district nurses would administer Mrs A's pain relief as required and they would order further supplies if she needed them. They said that district nurses could have started Mrs A on a syringe driver for continuous pain relief if required. The Board commented they were not aware of any accepted standard that palliative patients must be discharged home with a syringe driver.

Medical advice: pain relief

82. Adviser 2 considered there was an unreasonable failure to discharge Mrs A home with appropriate pain relief. Adviser 2 noted that Mrs A was prescribed morphine for pain and shortness of breath; which was to be injected hourly, as required. Adviser 2 explained Mrs A was given ten vials of morphine, which would equate to ten doses. Adviser 2 noted that if Mrs A was administered an injection of morphine hourly, this would only have lasted her ten hours. Adviser 2 considered this amount was insufficient for Mrs A, given she was at the end of her life. Adviser 2 explained that usually, a patient would be discharged with a week's supply of pain relief medication in these circumstances. Adviser 2 noted the Board's comments that the discharge medication was left open to interpretation so district nurses could give Mrs A pain relief medication as required. However, Adviser 2 considered the Board's recording of the discharge medication should have been more specific.

83. Adviser 2 explained it was unclear who was expected to give Mrs A these hourly injections of morphine. Adviser 2 said that when Mrs A was discharged home, medical staff should have considered how much pain relief medication she would require; and the best way of administering it to her. Adviser 2 explained that for end of life care, it would be best practice to use a syringe driver; which would continuously deliver a small amount of morphine. Adviser 2 said this would have avoided Mrs A needing constant morphine injections and it would have ensured she was getting an optimum amount of morphine for pain relief. Adviser 2 noted that during her hospital admission, Mrs A had been receiving two different types of subcutaneous morphine (injected under the skin). As such, Adviser 2 considered it was unreasonable Mrs A was discharged home without a syringe driver to continue that pain relief medication. Adviser 2 explained that without this, a carer would have had to give Mrs A hourly injections of pain relief medication.

84. Adviser 2 reviewed the Board's standardised protocol for discharging palliative care patients, which was implemented after these events. It sets out the steps that should be taken, such as: having a discussion with the patient/family about their wishes about being discharged home; making a referral to district nurses; putting in place discharge medication; and arranging patient transport. Adviser 2 confirmed the protocol was appropriate and they considered it will improve the process of patient handovers (between hospitals and district nurses) in future. However, this standardised protocol does not cover how pain relief medication should be prescribed or the circumstances in which it would be appropriate to use a syringe driver.

(d) Decision

85. The advice I received and I accept from Adviser 2 is that Mrs A was not discharged home with appropriate pain relief. I was advised and accept that; she was given only ten hours of pain relief medication, which was not enough. I was advised that if medical staff left the discharge medication open to interpretation so district nurses could give her medication as required, its recording should have been more specific. I was also advised and I accept that medical staff should have given Mrs A a syringe driver, as this would have avoided the need to give her hourly morphine injections.

86. I understand fully Mrs C and the family's concern that Mrs A was in pain, after she was discharged home for end of life care. I am troubled and concerned by the lack of evidence of any consideration being given to the impact hourly injections would have had on Mrs A and on her family, or how and by whom it should have been administered. I consider Mrs A should have been made comfortable in her final

hours, which she was not and this in turn had a significant impact on her family who had to witness her pain.

87. I uphold this complaint. Although the Board has introduced a protocol for the discharge of palliative patients, it does not address the specific issues we have identified about the appropriateness of the pain relief medication. You will find my recommendations for action by the Board are the end of this report.

(e) In August and September 2017, the Board failed to communicate reasonably with Mrs A and her family about her condition and treatment

Concerns raised by Mrs C

88. Mrs C complained about a lack of communication with Mrs A and her family. Mrs C said their family did not get clear explanations about Mrs A's condition and the reasons why she needed various treatments.

The Board's response

89. The Board acknowledged that their communication with Mrs A and her family was below the standard they would expect. They conveyed their sincere apologies to Mrs C for this. The Board said they should have ensured Mrs A's family was kept fully informed. The Board considered that if the communication had been better, it might have alleviated some of her family's concerns about her care and treatment. The Board explained they had shared learning from this complaint with relevant medical staff.

Medical advice: communication from medical staff

90. Adviser 1 described this as a complex case and they noted Mrs A was transferred within the hospital several times. Adviser 1 said the communication within individual medical teams appeared adequate and it was well documented. However, Adviser 1 considered it was likely that some communication issues were caused by medical staff in different teams giving information to Mrs A's family. Adviser 1 considered it would have been helpful if one member of medical staff had overall responsibility for Mrs A's care and for communicating with her family.

91. Adviser 1 went on to explain that often, medical staff who are performing complex surgery will phone the family immediately afterwards to explain how it went. Adviser 1 said this happens particularly when surgery is considered to be high-risk. This was not done in this case and Adviser 1 said although it would not have prevented Mrs A's post-surgery difficulties, it might have satisfied Mrs A's family that nothing appeared to have gone wrong during her kidney surgery.

Medical advice: communication from nursing staff

92. Adviser 2 explained that there was very little information about the communication between nursing staff and Mrs A's family in the medical records. Adviser 2 said that any important communication with the family should have been clearly recorded. Adviser 2 explained that due to the inadequacies in the record-keeping, they were unable to comment on the quality of the communication with Mrs A's family. Adviser 2 noted the Board had already accepted the communication was poor, which they considered was appropriate in the circumstances.

(e) Decision

93. In view of the advice received from Adviser 1 and Adviser 2; and the Board's acknowledgement that the communication with Mrs A's family was unreasonable, I uphold this complaint. I note that the Board has already apologised to the family for this and they explained they had shared learning with relevant staff. I consider this was an appropriate response to this failing. However, I have asked the Board to provide us with evidence of what the learning is and how it was shared. I have also provided them with feedback on how they might improve their communication in future, in light of my findings and comments made by Advisers 1 and 2.

94. 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 dates 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	What we need to see
(a) (b) (c) and (d)	• The decision to refer Mrs A for kidney surgery was unreasonable and there was a failure to evidence a robust multi-disciplinary team meeting (MDT) outcome and consent process; • There was an unreasonable delay in diagnosing and treating Mrs A's haemothorax; • There were failings in Mrs A's nursing care; and • Mrs A was discharged home without appropriate pain relief	Apologise to Mrs A's family for the failings in her medical and nursing care. The apology should meet the standards set out in the SPSO guidelines on apology available at http://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology. By: 19 March 2020

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	The decision to refer Mrs A for kidney surgery was unreasonable	In similar circumstances, full consideration should be given to non-surgical treatment options for patients with renal cell carcinoma, in accordance with the relevant guidance	Evidence that these findings have been fed back to the relevant staff and managers in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 20 April 2020
(a)	The urology MDT outcome; and the discussion and/or record-keeping was inadequate	• All potential treatment options should be discussed by urology MDTs and then clearly recorded to facilitate proper engagement with the patient. • Urology MDTs should provide and record an expert opinion on patient management and treatment	Evidence that the Board's urology MDT approach ensures MDT meetings are appropriately recorded and an expert opinion on management and treatment is given. By: 20 April 2020

Complaint number	What we found	Outcome needed	What we need to see
(a)	The consent process for Mrs A's kidney surgery was unreasonable. There was a failure to discuss and record the risks of Mrs A not having kidney surgery, as well as the non-surgical treatment options	Patients should be fully advised of: • the risks relating to both having and not having surgery; and • any non-surgical treatment options. Those discussions should then be clearly recorded as part of the consent process	Evidence that this has been fed back to relevant medical staff in a supportive manner that encourages learning. The SPSO thematic report on informed consent may assist in encouraging learning for staff in this area: http://www.valuingcomplaints.org.uk/spso-thematic-reports By: 20 April 2020
(b)	There were unreasonable failings in diagnosing and treating Mrs A's haemothorax	Patients should be given timely comprehensive assessments and an appropriate diagnosis	Evidence that this case has been used as a learning tool for relevant medical staff, in a supportive way that encourages learning, to help ensure that an appropriate and timely diagnosis is reached in cases such as this. By: 19 May 2020
(c)	There were a number of failings in the nursing care provided to Mrs A in relation to pressure ulcer prevention	Patients should receive nursing care to prevent and manage pressure ulcers in line with relevant standards and the Board's own guidance	Evidence that the Board have reviewed the training needs of nursing staff in relation to the diagnosis, grading, prevention and management of pressure ulcers. By: 19 May 2020

Complaint number	What we found	Outcome needed	What we need to see
(c)	There were a number of failings in the nursing care provided to Mrs A in relation to managing her diabetes	Patients should receive nursing care in relation to managing their diabetes in line with relevant standards and the Board's own guidance	A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned. By: 19 May 2020
(c)	There were a number of failings in the nursing care provided to Mrs A in relation to nutritional care	Patients should receive adequate nutritional assessment and care planning in accordance with relevant standards	A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned. By: 19 May 2020
(d)	Mrs A was discharged home for end of life care with insufficient pain relief medication	Patients discharged home for end of life care should be given sufficient and appropriate pain relief medication with clear instructions on how it is to be administered and by whom	• Evidence that appropriate guidance/protocols are in place for palliative pain relief; and • Evidence that the findings on this complaint have been fed back to relevant medical staff in a supportive manner that encourages learning. By: 20 April 2020

We are asking the Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a) (b) (c) and (d)	The Board's own complaints investigation did not identify or address all of the failings in Mrs A's medical and nursing care	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement	Evidence that the Board have reviewed why its own investigation into the complaint did not identify or acknowledge all the failings highlighted here and what learning they identified and what changes (if any) they will make. By: 19 May 2020

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	Outcome needed	What we need to see
(c)	The Board acknowledged there were times when Mrs A's bed table was left out of reach	The Board said they had discussed the need to ensure that bed tables are left within easy reach of patients with relevant nursing staff	Evidence that this was discussed with relevant nursing staff and whether any changes will be made as a result. By: 20 April 2020
(e)	The Board acknowledged their communication with Mrs A's family about her condition and treatment was unreasonable	The Board confirmed that they had shared learning with relevant staff	Evidence that the learning was shared with relevant staff. By: 20 April 2020

Feedback

Points to note

Based on the advice I accepted, I am sharing the following which I encourage the Board to consider and reflect on their practice in light of them:

- Many surgeons who are performing complex surgery, especially high-risk surgery, will phone the patient's family immediately afterwards to explain how it went. The Board might wish to consider doing this in future.
- It would have been beneficial if Mrs A had remained under the care of one senior member of medical staff, even when she was transferred within the hospital.
- If possible, one member of medical staff should have been responsible for updating Mrs A's family on her condition and treatment.
- To facilitate good communication, it might be helpful for the Board to develop guidance on what should be communicated to families; how it should be communicated; and how to record this.
- It might be helpful for the Board to develop a communication record, as it would enable all communication to be logged. This could include sections to record the following information: the time; the date; the name of the person; and what information was communicated.

Response to SPSO investigation

- I issued this report to the Board as a draft and invited them to provide comments within 20 working days. The Board requested an extension to respond, which was granted. However, they did not provide their comments within the extended timescale. I am deeply concerned about this delay at this stage in my investigation, especially given the amount of input the Board had already had, and their detailed knowledge of the issues under investigation. I am also concerned about the impact this delay had on Mrs C and her family. The Board have provided me with reasons for this delay and have apologised for it, but I would ask them to reflect on the experience of the complainant and the impact of the delay.
- The Board provided my office with additional records relating to the urology MDT when responding to the draft report. While this does not amount to a shortcoming that requires a recommendation on this occasion, I strongly urge the Board to reflect on how they ensure they provide the SPSO with all relevant information as part of our initial enquiry, and whether that information was appropriately taken into account in their own stage 2 investigation. Where I see repeat failings of this nature, I may choose to take remedial action through my complaints standards powers.

active surveillance	monitoring the size of a kidney lesion with imaging
Adviser 1	a consultant urologist who provided medical advice on Mrs A's care and treatment
Adviser 2	a registered nurse who provided medical advice on Mrs A's care and treatment
Adviser 3	a consultant respiratory physician who provided medical advice on Mrs A's care and treatment
angina	chest pain caused by reduced blood flow to the heart
artery	vessels that carry blood from the heart
blood glucose levels	the level of sugar in the blood
cardiology	medical specialty dealing with disorders of the heart
chest drain	a flexible plastic tube is inserted through the chest wall and into the affected area to drain it of fluid
consultant anaesthetist	a clinician who is responsible for giving anaesthesia to patients and monitoring their condition during surgery
consultant cardiologist	a clinician who treats disorders of the heart
consultant respiratory physician	a clinician who treats disorders affecting the breathing system
consultant urological surgeon	a clinician who treats disorders of the urinary tract

CT scan	a (computerised tomography) scan using x-rays and a computer to create detailed images of the inside of the body
CT scan with contrast	a scan where dye injected into the body is used to make blood vessels and tissues more visible
delayed intervention	delaying treatment until a kidney lesion is found to have increased in size
effusion	excess fluid around the lung
haemoglobin	a protein molecule in red blood cells
haemothorax	a collection blood in the lung cavity
hypotension	a drop in blood pressure
lesion	an area of damage
MDT	multi-disciplinary team meeting
morphine	a drug for relieving moderate to severe pain
Mrs A	the aggrieved
Mrs C	the complainant and daughter of Mrs A
MUST	malnutrition universal screening tool – used to identify patients at risk of malnutrition
pressure ulcer	an injury to the skin and underlying tissue, usually caused by prolonged pressure
QPI	quality performance indicator
renal cell carcinoma	a type of kidney cancer

respiratory	specialists in treating disorders of the breathing system
stent	small tube made of metal mesh to help blood flow more freely
surgical high dependency unit	a unit where patients can be treated more extensively than on a standard ward
syringe driver	a machine that delivers continuous pain relief medication
the Board	Tayside NHS Board
the hospital	Ninewells Hospital
urology/urologist(s)	specialists in treating disorders of the urinary system
VATS	Video-assisted thoracic surgery - a type of chest surgery using a small camera

List of legislation and policies considered **Annex 2**

Care of Older People in Hospital Standards Health Improvement Scotland (2015)

Communication, Partnership and Teamwork General Medical Council (2014)

Consent: patients and doctors making decisions together General Medical Council (2008)

CPR for Feet Scottish Diabetes – Foot Action Group (2015)

Diabetic Guideline - Glucose Control in SHDU NHS Tayside

Patient Partnership for Insulin Administration NHS Tayside

Pressure Ulcer Prevention Treatment Plan NHS Tayside

Guidelines for the Use of the CME T34 Syringe Pump for Adults in Palliative Care Health Improvement Scotland (2011)

Management of haemothorax Parry GW, Morgan WE, Salama FD. *Ann R Coll Surg Engl*. 1996; 78(4): 325–326.

Prevention and Management of Pressure Ulcer Standard Health Improvement Scotland (2016)

Renal Cell Carcinoma the European Association of Urology guidelines (updated 2017)

Renal Cancer Guideline the American Urological Association guidelines (April 2017)

Renal Cancer Quality Performance Indicators NHS Scotland (2016)

Scottish Wound Assessment and Action Guide Health Improvement Scotland (2010)

Standards for Food, Fluid and Nutritional Care Health Improvement Scotland (2014)