SPSO decision report

Case: **201300583, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that her late father (Mr A) received at University Hospital Ayr for prostate cancer and the palliative care (care to prevent or relieve suffering only) he had at home during the last weeks of his life. Mrs C said that her father's cancer was not properly monitored, and that this meant that doctors were not aware when it started to spread. She complained that had he been properly monitored this could have been treated, he would have lived longer, and would have suffered less pain. She also complained that the palliative care was inadequate and, because he was too unwell to be at home, this led to him being transferred to a hospice shortly before his death, against his wishes.

We took independent advice from two of our advisers - an oncology adviser (cancer specialist) and a nurse. The oncology adviser found that there were monitoring failures, with appointments cancelled and not reinstated. However, he said that Mr A was given appropriate treatment, and that the delay in some consultations did not affect the decisions doctors made about treatment. Our nursing adviser said that Biggart Hospital, where Mr A was an in-patient towards the end of his life, should have involved the district nurse in planning for his discharge while he was still in hospital. She also said that once the district nurse was involved, Mr A's palliative care was not sufficiently assessed and planned, and that the family's needs were not appropriately taken into account. She was critical that the family's concerns were not responded to when they were first raised, and continued to be overlooked, even when Mr A was becoming very unwell.

On the basis of the advice we received, we found that the board did not monitor Mr A's cancer appropriately. However, they had already identified this and had taken steps to ensure this did not happen again. We did not consider that this failing had any significant impact on Mr A's medical treatment. In relation to Mr A's palliative care, we found failings by both hospital and district nursing staff.

Recommendations

We recommended that the board:

- ensure that all patients receive clear information on how prostate cancer is monitored, what treatment options are available, and when they might be applicable;
- review arrangements for the discharge of terminally ill patients to ensure district nursing staff are fully involved in discharge planning;
- ensure all district nursing staff have up to date training in their role in the provision of palliative nursing care; and
- apologise to Mrs C and her family for the considerable distress experienced by her father and her family, due to the board's failure to provide appropriate palliative care in the final weeks of Mr A's life.