SPSO decision report

Case: **202303401, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C raised concerns about the care and treatment provided to their sibling (A). A underwent a series of hospital admissions, suffering from bleeding from their bladder, following radiotherapy. During these admissions, the majority of communication between the board and the family was with A's partner (B). A was initially expected to recover from the radiotherapy but was admitted and discharged repeatedly, with some readmissions happening a matter of hours after A was discharged. A continued to deteriorate and died in hospital.

C believed that A was not provided with an adequate standard of urological or nursing care. They felt that A was not provided with appropriate treatment and that they were not reviewed properly by other medical specialties, given the complexity of their case. C was also concerned that A was not provided with adequate nursing care. C believed that the board had not acknowledged systemic failings which impacted on A's care, wellbeing and adversely affected the outcome of their treatment.

We took independent advice from a consultant urologist and a registered nurse. We found that A's urology care fell below a reasonable standard, as did their nursing care and we upheld these aspects of the complaint.

We found that A was reviewed appropriately by other medical specialties and this aspect of C's complaint was not upheld.

Finally, the opportunity to perform surgery on A was missed and this contributed to A's deterioration. It was not possible, however, to determine whether A would have survived if their care had been different. The board failed to transfer A to a different consultant or offer a second opinion when this was requested and they failed to communicate reasonably with A's family about their care. We upheld these aspects of the complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should apologise separately to C & B for the failures in A's care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Improved management of long-term or complex patients, with clear communication between different medical specialties. The board should review the management approach to long-term complex patients, focusing on the shared care arrangements between differing specialties.
- Patients admitted to hospital should receive appropriate nursing care including appropriate nutritional and fluid intake monitoring, when requested as part of their care plan.
- A review of whether urology patients can be provided with a dedicated ward, or part of a ward.
- Consultant care transfer and second opinion requests should be managed reasonably and transparently.

- Patients should receive adequate nutritional support to support their treatment and recovery. The board should develop an action plan, reviewing A's case and identifying learning for the staff involved in A's care.
- Patients admitted to hospital should receive reasonable medical care including being offered appropriate treatment options, nutrition, and review after transfer from HDU. Clinical correspondence should be completed to an appropriate standard.
- Patients admitted to hospital should receive appropriate nursing care including appropriate recording of their patient centred care plan.
- Patients admitted to hospital should receive appropriate nursing care including recording and management of wounds or pressure injuries.
- Decisions on surgery should be explained to the patient whenever possible, allowing the patient or their family to make informed decisions about their treatment.

In relation to complaints handling, we recommended:

- Complaint responses should be clear and written in plain English whenever possible. Where clinical terms or technical language is used, this should be clearly explained in the body of the letter.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.