SPSO decision report

Case: **201202607, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C complained that the medical and nursing care and treatment provided to her late mother (Mrs A) was inadequate. She also complained about inadequate communication between staff and her late mother and the family. Mrs A was admitted to hospital suffering from a blood clot in the intestine which then caused problems with her bowel. She had surgery several times while in hospital and was transferred to the intensive care unit (ICU), where she died some three weeks after being admitted.

In relation to the medical treatment, Miss C complained that when Mrs A was taken into hospital with sudden abdominal pain, there were delays in obtaining a diagnosis; in undertaking investigations; and in addressing her level of pain. Miss C also complained that it was unreasonable to have transferred Mrs A from the Accident and Emergency department to the Surgical Observation Unit before transferring her to an in-patient ward. During our investigation we took independent advice from one of our medical advisers, an experienced surgeon, who was of the view that Mrs A's medical care and treatment had been reasonable. The blood clot had caused tissue in Mrs A's intestine and bowel to die, and the adviser said that diagnosis of this condition is largely one of elimination of possible causes and that there had been no unreasonable delays in investigating and treating Mrs A's condition. The adviser said that the condition can be very painful but that strong painkillers can mask physical symptoms and so it was not unreasonable that it took some time to get Mrs A's pain under control. We did not, therefore, uphold Miss C's complaints about her late mother's medical treatment.

In relation to the nursing care and treatment, we also took independent advice from our nursing adviser, who had concerns over some of the issues Miss C had raised. In particular she was concerned about monitoring and observations, record-keeping, pain scoring, and communication by nursing staff. There were also problems with the communication of a decision to reverse a Do Not Attempt Resuscitation decision (DNAR - a decision taken that means a doctor is not required to resuscitate the patient if their heart stops) from medical staff. While the medical adviser was satisfied that both the original DNAR decision and the reversal decision were appropriately taken, only the original decision was discussed with the family. While such decisions are clinical ones and do not require approval or consent from the patient or family, it is good practice to discuss these issues where possible. Overall, we upheld Miss C's complaints about nursing care and communication.

Recommendations

We recommended that the board:

- apologise to Miss C and her family for the failings identified during this investigation;
- provide evidence that the standards of record-keeping meet the required professional standards across the wards/units involved in this complaint and, where necessary, provide training to meet these standards;
- ensure that there are robust systems for handover between the clinical departments identified when patients are transferred;
- ensure that the knowledge and skills of the nurses involved in this complaint when performing clinical observations, including pain assessments, meet the relevant local guidance;

- ensure that staff on the ICU ensure that alternative support strategies are in place for families/carers when visiting arrangements are reviewed; and
- remind all staff involved in this complaint of the importance of good communication between staff and patients and their families/carers.