SPSO decision report

Case: **201203596, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C (an MSP) made a complaint on behalf of his constituent (Mrs B) about the clinical treatment and nursing care provided to Mrs B's late mother (Mrs A). The complaints included a delay in undertaking a CT scan (a specialised type of

x-ray using a computer); the insertion and monitoring of a drain to remove fluid from Mrs A's abdomen; and failures in communication.

We upheld Mr C's complaint and made a number of recommendations. Our investigation included taking independent advice from two of our medical advisers - an oncologist (a cancer specialist) and a senior nurse. Both advisers were critical that there was a lack of documentation about Mrs A's care and treatment, and noted that this made it difficult to know what had or had not been done for her. Our investigation also found that there were many failures in communication between staff and Mrs A and her family. This was particularly difficult for the family when Mrs A was nearing the end of her life and was placed on the Liverpool Care Pathway (a tool used to assist clinicians and nursing staff to support patients and their families as the patient is dying. The aim is to address the patient's symptoms rather than aggressively pursue a cure for the underlying terminal condition.)

We also noted that there was a delay of some four weeks before the radiology department received an urgent CT scan request made by Mrs A's GP, and then it was a further two weeks before the scan took place. The board could provide no explanation for this delay other than human error in not following it up. While the delay was unlikely to have altered the eventual outcome for Mrs A, we found it unacceptable.

Recommendations

We recommended that the board:

- remind all staff involved in processing requests for referrals and investigations of the importance of arranging appointments to meet the two-week NHS target time;
- ensure that all relevant staff are made aware of the revised medical protocol for the management of ascites (fluid)/drainage;
- ensure that all relevant staff are made aware of the requirement to seek informed consent for any invasive procedure to be undertaken, and where necessary provide appropriate training;
- conduct an audit of record-keeping in the ward concerned, and address any learning issues identified;
- remind all relevant staff of the need for effective communication with patients, relatives and/or carers, and provide refresher training where necessary; and
- apologise for all of the failings identified during our investigation.