SPSO decision report

Case: **201300630, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C's late mother (Mrs A) was admitted to Hairmyres Hospital on numerous occasions during 2012 due to heart problems. She was admitted from mid September to early October with unstable angina and, following admission to another ward a week later, she was under the care of a cardiologist (heart specialist) who thought she might have a chest infection and said that antibiotics should be prescribed. Mrs C said that while on this ward Mrs A was unable to eat and was prescribed large amounts of medication for heartburn and acid reflux. On the day of her discharge, Mrs A was seen by a dietician who noted that her food intake was poor and that Mrs A disliked hospital food. Antibiotics were not prescribed. Shortly after discharge, Mrs A's GP diagnosed her with a chest infection, and prescribed antibiotics. Mrs A was re-admitted to hospital by emergency ambulance three days after being discharged and died six days later. The death certificate stated the cause of death as infection of unknown origin, acute kidney injury (abrupt loss of kidney function), chronic renal impairment (gradual loss of kidney function), recent myocardial infarction (heart attack) and ischaemic heart disease (when the arteries narrow).

Mrs C complained that when Mrs A was discharged, she was already suffering from the infection that contributed to her death, and that communication by staff was inadequate. She was also concerned about what she described as the appalling meals being served to vulnerable people and said that it was unacceptable that families had to feed their relatives in hospital.

We found the board unreasonably failed to carry out a test and to prescribe antibiotic treatment, so we upheld this complaint. However, we noted the independent advice of our medical adviser who said that, although not prescribing antibiotics was a significant medical failure, even if they had been prescribed earlier they would not have had a significant effect on the outcome. Nonetheless, this caused a great deal of distress to Mrs C who was left with uncertainty about its impact on Mrs A's death. Problems with communication also meant that it appeared Mrs C and her family were unaware of how unwell Mrs A was during her second last admission to hospital.

In relation to the complaint about dietary requirements, we found no evidence of any shortcomings in respect of food and nutrition. Our investigation found that Mrs A was referred to a dietician at the right time, was seen within a reasonable time and that food and fluids charts were started when appropriate.

Recommendations

We recommended that the board:

- carry out a significant event analysis to address why a c-reactive protein test was not carried out, why antibiotics were not commenced and the communication failure; and
- apologise to Mrs C for the failures identified.