

## SPSO decision report

**Case:** 201302977, Lanarkshire NHS Board  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Outcome:** some upheld, recommendations

### Summary

Mr C was admitted to Monklands Hospital with suspected kidney damage. He was already suffering from end stage alcoholic liver disease. Mr C was initially cared for in the Emergency Receiving Unit (ERU), where he fell twice. He was then transferred to a ward. Mr C's condition continued to deteriorate. Four days after he was admitted he was reviewed by a consultant, and staff contacted his wife (Mrs C) and asked her to come to the hospital urgently as he was considered to have a very poor prognosis. Mr C died that day.

Mrs C complained that her husband did not receive appropriate medical or nursing care when admitted to hospital, and that he was not properly assessed as a fall risk whilst in the ERU. She also said that when he was transferred from the ERU to a ward there was no proper handover and nurses had lost a crucifix he wore. This was returned to her after he died, but had been irreparably damaged. Mrs C said that medical staff were slow to assess her husband's problems and failed to provide him with the appropriate treatment, as they had not considered him for a liver transplant. She was also unhappy with the board's response to her complaint, which listed Mr C's entire medical history and emphasised the role alcohol had played in his ill health, which she felt was insensitive.

We took independent advice from a medical adviser and a nursing adviser. The medical adviser said that although the medical treatment provided to Mr C was appropriate, communication by medical staff fell below a reasonable standard. He said that they had not discussed with Mrs C the decision to designate her husband as 'Do Not Attempt to Resuscitate' (DNAR - a decision taken that means a doctor is not required to resuscitate the patient if their heart or breathing stops). They had also not explained either his poor prognosis or the decision not to refer him for a liver transplant, contrary to General Medical Council guidance. The adviser said that the decision not to refer Mr C for a transplant was, however, in itself reasonable in the circumstances.

The nursing adviser said the standard of basic nursing care was reasonable, but the record-keeping of staff in ERU fell below an acceptable standard. They had not completed the falls assessment in a timely fashion and had not responded quickly enough to Mr C's first fall. It was not possible to be certain his second fall could have been prevented, but nursing staff had not taken the appropriate action, which was unacceptable. The adviser also said staff had not shown empathy or compassion to Mrs C while her husband was dying, and end of life care was a key part of the nursing and midwifery code.

We upheld most of Mrs C's complaints, as our investigation found that the nursing and medical care provided to Mr C fell below an acceptable standard. We did not uphold the complaint that he was not considered for a transplant.

### Recommendations

We recommended that the board:

- apologise in writing for the failings identified in our investigation;

- ensure patients are provided with up to date information on their suitability for liver transplant referral;
- remind all nursing staff responsible for Mr C's care of the importance of communication with family members during end of life care;
- remind nursing staff in the ERU of the importance of ensuring records are accurate and contemporaneous;
- remind nursing staff in the ERU of the importance of the timely assessment and implementation of falls reviews;
- review their procedures for assessment and care planning for patients at risk of falls;
- review the handover process for ERU staff to ensure that it is being carried out appropriately;
- remind the medical staff responsible for Mr C's treatment that where a patient has been designated DNAR for medical reasons, the earliest opportunity should be sought to discuss this with the patient and their family; and
- remind the medical staff responsible for Mr C's treatment of the importance of discussing a patient's prognosis with them and their family at the earliest opportunity.