SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201305791, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that her late husband (Mr C) received at Wishaw General Hospital. Mr C had advanced cancer and was admitted to the hospital because he was vomiting blood. He was in the hospital for about a week before being transferred to a hospice, where he died shortly after. Mrs C complained that the hospital did not adequately assess and treat her husband's bladder and bowel problems and failed to take adequate precautions to prevent him from falling out of bed. She also complained that neither she nor Mr C had been involved in discussions about the withdrawal of his medical treatment and his future management plans.

We took independent medical advice from an experienced hospital doctor, who reviewed Mr C's records. Our adviser said that although it was clear that Mr C was most unwell when he was admitted, there were a number of steps the hospital should have taken sooner. Viewed as a whole, he said that Mr C's care fell below a reasonable standard and we upheld this complaint.

We also took independent advice from our nursing adviser, who said that a falls assessment was completed when Mr C was admitted. This indicated that he was not at risk of falling and, in her view, there was no reason for the hospital to have suspected he might do so. Our adviser said the hospital's assessment was reasonable and the board had acted reasonably, based on the information available at the time. In her view, Mr C's fall could not have been avoided, and we did not uphold this complaint.

In terms of Mrs C's complaint about the lack of discussions, our medical adviser pointed to an apparent lack of clarity around the approach being taken with Mr C's care. He was moved to the hospital's high dependency unit for treatment – despite the notes indicating he would not be moved – but it was then decided to move him onto palliative care (care provided solely to prevent or relieve suffering). Our adviser said that this decision was appropriate but should have been discussed sooner than it was. We took the view that the evidence showed a lack of certainty over the direction of Mr C's care and that his family were given mixed messages. We considered this unreasonable and upheld this complaint.

Recommendations

We recommended that the board:

- discuss this case at the next departmental meeting to ensure early recognition of kidney dysfunction and infection, so appropriate steps are taken in such cases;
- ensure that the failings in care and treatment identified are fed back to the relevant staff;
- provide us with a copy of their local action plan for the relevant Scottish Government guidance and confirm the steps in place in acute wards to support patients and families receiving end of life care including staff communication;
- use this case in Mr C's consultant's appraisal with reflection on the issues identified, including the decision on when to move to palliative care, communication and consultant supervision; and
- apologise to Mrs C for the failings we identified.