SPSO decision report

Case: **201306304, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the care provided to her when she was admitted to the Western General Hospital (the hospital). Ms C, who lives within another board area, was visiting Edinburgh when she became ill with abdominal pain, severe constipation, and vomiting. She attended the A&E department of another hospital in the board's area and was transferred to the hospital. Ms C was seen by one consultant on admission who said that he planned to do a sigmoidoscopy (an investigation of her intestines by way of a flexible camera) the following day.

The next day Ms C was reviewed by a different consultant who said that the sigmoidoscopy was not necessary and that it would be better for her treatment to be undertaken at her home hospital, where she had previously been treated for a condition involving her intestines. No treatment was provided for Ms C's constipation; her pain was not sufficiently addressed; and when she was discharged on the Saturday, she was told to self-refer to the hospital nearer her home (in another board area) for treatment on the following Monday.

We took independent advice from one of the our medical advisers and a nursing adviser who were of the view that Ms C's condition could and should have been investigated and treated at the hopsital. The medical adviser was of the view that if the team at the hospital felt specialist input was needed from a hospital in another board, Ms C should have been transferred there in a formal process rather than told to self-refer. The result was that Ms C's condition went untreated from Thursday to the next Tuesday as Ms C was admitted to the hospital in another board area on the Monday but there was then a delay in sending the result of a scan done in the hospital to another hospital nearer Ms C’s home.

Ms C also complained that some of the responses from the board to her complaint were inaccurate and this was upheld as some of the matters referred to were not documented in the clinical notes.

Recommendations

We recommended that the board:

- take action to remind all staff involved in this complaint of the importance of effectively monitoring, recording and addressing patients' pain;
- ensure all the staff involved are made aware of the findings in this case;
- give consideration to formulating guidelines on adequate arrangements for patients being discharged for on-going care which is expected to take place at a different institution;
- remind all staff involved in this complaint of the importance of effectively monitoring, investigating, recording and addressing patients' care and treatment;
- remind all staff involved in this complaint of the importance of accurately responding to complaints, based on the clinical records and other evidence available; and
- issue an additional written apology for the failings identified during this investigation.