SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201403532, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the treatment received by her late father (Mr A) during two admissions to Hairmyres Hospital and at an interim out-patient appointment. During his first admission, Mr A was diagnosed with cirrhosis of the liver (scarring of the liver). He was then seen by a nurse specialist in an out-patient clinic. He was re-admitted via A&E two days later and was treated for sepsis, but his condition declined rapidly and he died the following day.

Mrs C complained that adequate investigations were not carried out during Mr A's first admission. We obtained independent advice from one of our medical advisers, who considered that Mr A had been appropriately assessed. We did not uphold this complaint. Mrs C also raised concerns that the discharge was not discussed with her family and they were not given information regarding Mr A's new diagnosis. The board agreed that more could have been done and they agreed to discuss this at a forthcoming nurse debrief meeting. However, the adviser noted that this failing still needed to be addressed from a medical point of view. We upheld this complaint.

Mrs C was unhappy that the nurse specialist did not arrange to re-admit Mr A. The adviser said re-admission should have been arranged when results from blood tests taken at the out-patient clinic became available. This did not happen and we upheld this complaint. Mrs C also complained that there was a delay in admitting Mr A when he subsequently attended A&E. The adviser confirmed that Mr A received appropriate treatment during his wait and we did not uphold this complaint. Finally, Mrs C complained of a delay in releasing Mr A's body to the undertaker. We considered that this had been arranged within a reasonable timeframe and we did not uphold this complaint.

Recommendations

We recommended that the board:

- review the communication by medical staff surrounding Mr A's discharge, with a view to making improvements, and report back to us with their findings;
- draw this decision to the attention of the nurse specialist and develop an action plan to address the concern that admission was delayed in this case. They should notify us when this has been done; and
- apologise to Mrs C and her family for the identified delay in arranging to re-admit Mr A to hospital.