SPSO decision report

Case: **201404208, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C complained about the medical and nursing care that her late mother (Mrs A) received at the Royal Infirmary of Edinburgh after she was admitted with upper abdominal pain. Miss C felt there had been a delay in a scan being performed which contributed to Mrs A's premature death from cancer; that there was a lack of communication from the staff about the severity of Mrs A's illness; that a decision had been made not to resuscitate Mrs A without this being discussed with the family; and that nursing staff should have monitored her mother's condition more closely.

We took independent advice from our medical adviser who found that there had been an unreasonable delay in the scan being done, although an earlier scan was unlikely to have altered Mrs A's prognosis. Had the scan been done two days earlier, Mrs A and the family could have been informed of the diagnosis in a more timely manner before her death several days later. The board said that the delay was due to the ward being closed because of an infection. However, we concluded that infection control measures could have been put in place, so we upheld the complaint. We also found that there was a lack of records to provide evidence that the medical team clearly communicated, to either Mrs A or the family, about the strong suspicion of cancer. Furthermore, we considered it was unreasonable that the family were not given the opportunity to be involved in the medical decision about resuscitation. In terms of the nursing care, we found evidence that reasonable checks were carried out. Furthermore, the medical staff noted that nursing staff had raised concerns with them about Mrs A's deteriorating condition. We did not uphold the complaint but recommended the board share with nursing staff the importance of recording when such action is taken.

Recommendations

We recommended that the board:

- apologise for the delay in performing the scan;
- share the findings about the delay in the scan with relevant staff to prevent this recurring;
- share with relevant nursing staff the need to make accurate records in line with guidance issued by the Nursing and Midwifery Council;
- ensure that doctor 1 reflects on the failings in relation to communicating with patients about suspected diagnosis at his next appraisal; and
- draw the findings about the lack of discussion about the decision not to resuscitate Mrs A to the attention of doctor 2.