SPSO decision report

Case: **201404806, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C, who is an advocacy worker, complained to the board on behalf of her client (Mrs B). Mrs B's mother (Mrs A) had been admitted to Forth Valley Royal Hospital with swallowing difficulties, and there was a problem when a nurse was performing an endoscopy (a procedure where a tube-like instrument is put into the body to look inside). A consultant gastroenterologist (a doctor specialising in the treatment of conditions affecting the liver, intestine and pancreas) was called to continue the procedure and Mrs A's oesophagus was perforated, which meant the procedure had to be cancelled. Mrs A was transferred to the intensive care unit (ICU) and Mrs B complained that Mrs A suffered problems with her catheter, blockages of her NJ tube (nasojejunal tube - a small tube that is passed through the nose and into the small intestine), inappropriate management of her chest drain, and poor communication from staff.

The board maintained that the perforation of the oesophagus was a rare but recognised complication of an endoscopy procedure and that Mrs A was transferred to ICU for close monitoring. They said Mrs A had received appropriate care and treatment, and that it was appropriate for the catheter to have been fitted. They said the blockages in the NJ tube were addressed in a timely manner, and explained that staff dealt appropriately with problems of fluid build-up by managing chest drains correctly.

After taking independent advice from a gastroenterologist adviser and a nursing adviser, we did not uphold the complaint about the care and treatment which Mrs A received. We found that Mrs A had suffered a recognised complication of an endoscopy procedure which was not caused by failings by the staff involved. We were also satisfied that the staff provided Mrs A with appropriate care and treatment in relation to the problems with her catheter, NJ tube and chest drain management. However, we did find that, although communication from the staff to the family was generally good, there was a four-day period after Mrs A's transfer to ICU when senior staff did not provide her family with an update.

Recommendations

We recommended that the board:

- apologise to Mrs A for the failings in communication from ICU staff;
- take steps to ensure the relevant staff are made aware of the importance of communication with relatives, in line with General Medical Council guidance; and
- remind staff who compile draft complaint response letters to ensure that all relevant issues are included.