SPSO decision report

SPSO Scottish Public Services Ombudsman

Case:	**201507743, Lothian NHS Board**
Sector:	health
Subject:	clinical treatment / diagnosis
Outcome:	upheld, recommendations

Summary

Miss C complained about the care received by her brother (Mr A) at the Royal Infirmary of Edinburgh following a suspected drug overdose. During his admission, Mr A was drowsy and had slurred speech. Mr A was moved to the acute medical unit and received treatment for a chest infection. He also had a scan to check for a blood clot on the lung. No blood clot was found and Mr A was to be discharged. On the morning of his discharge, he experienced a cardiac arrest and died.

We took independent nursing and medical advice. The nursing adviser was satisfied that nursing staff had noted Mr A's condition but raised concerns that Mr A's oxygen saturation (the relative measure of the amount of oxygen in the blood) was abnormally low during the admission. Whilst nursing staff had noted this, they had not informed medical staff.

The medical adviser considered that Mr A had received appropriate care and treatment for the first two days of his admission, but that Mr A's low oxygen saturation should have resulted in a medical review on the evening before discharge. They noted that a possible explanation for the omission of a review was that staff considered his oxygen levels to be low as a result of drug use, rather than his chest infection. The medical adviser noted that staff could have considered administering a medication which temporarily reverses the sedative effects of drugs to help them determine the reason for low oxygen levels. The adviser could not say whether better care at this time would have prevented Mr A's death. However, they considered that the treatment provided to Mr A was unreasonable. We upheld this aspect of Miss C's complaint.

Miss C also complained that staff had failed to respond reasonably to concerns raised by Mr A's family. The medical adviser noted that Miss C had spoken to a doctor on the evening before the planned discharge. The adviser was critical that the doctor had informed Miss C that Mr A was well enough for discharge, when the evidence available at that time did not support this. They considered that there was evidence that staff had shown a lack of appreciation for the family's concerns, and we therefore upheld this aspect of the complaint.

Miss C also complained about the board's handling of her complaint. We noted that the board had met with Miss C and Mr A's family and had also taken steps to investigate the concerns raised by Miss C. We were critical that the board delayed interviewing staff regarding Miss C's complaints and that the board did not update Miss C about the delay in arranging a second meeting. While we noted that the board had responded in writing to aspects of Miss C's complaints, we were critical that they did not conclude their investigation with a definitive final response or inform Miss C in writing of what to do were she not happy with their response. We also noted that Miss C had not received a copy of a substance misuse leaflet that the board had agreed to provide. We upheld this aspect of Miss C's complaint.

Miss C also complained that Mr A's medical records inaccurately stated that his family had given him drugs. We found that the discharge letter did not explicitly state this, but that staff did have concerns that Mr A's family had brought him drugs. The medical adviser noted that there was no suggestion in the letter that any additional drugs

caused Mr A harm, and no indication that the letter was directly critical of the family. However, they found that the letter contained a statement that was not supported by the clinical notes and that there was no clear evidence in the records of specific additional drug use, or evidence of involvement of the family related to the drug use. The adviser considered that the statement was unreasonable. We therefore upheld this complaint.

Recommendations

We recommended that the board:

- feed back the comments of the advisers to medical and nursing staff in the acute medical unit;
- issue a written apology to Mr A's family for the failings in nursing and medical care identified by the advisers;
- provide evidence that the learning from this complaint has been implemented;
- issue a written apology to Mr A's family for failing to respond reasonably to the concerns that were raised;
- issue a written apology to Miss C for the complaints handling failings identified in this investigation;
- feed back to staff the importance of interviewing staff within good time of events, of concluding a complaint investigation with a written report and of updating complainants with the progress of the investigation where delays occur;
- provide Miss C with a copy of the substance misuse leaflet and details of the steps taken to improve communication;
- feed back the comments of the adviser to the member of staff who wrote the discharge letter;
- make an addendum to the records, which notes that the statement about the family in the letter was not reflected in the clinical notes, and send a copy of this addendum to Practitioner Services to be filed with Mr A's GP records; and
- issue a written apology to Mr A's family for the inaccurate statement in the records.