SPSO decision report

Case: **201508659, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Ms A) about the care and treatment she had received at Wishaw General Hospital. Ms A suffered a stroke-like episode and was taken to hospital by ambulance. Following medical investigation, Ms A was discharged a few days later with a probable diagnosis of multiple sclerosis (MS). Although her discharge documents detailed this probable diagnosis, Ms A complained that a doctor had made a specific diagnosis of MS and that this was not in line with national guidance which states that MS should not be diagnosed in a general hospital setting. Ms A was also concerned that the medical investigations that were carried out and the delay in referring her to neurology were unreasonable. We also considered whether the handling of and response to the complaint was reasonable.

After taking independent advice from a consultant physician, we did not uphold the complaints regarding medical investigations or neurology referral. We found that the investigations were timely and appropriate for the symptoms that Ms A presented with. We found that board staff had a different recollection of Ms A being advised of the outcome of the medical investigations and that while Ms A was certain that a definitive diagnosis had been provided, staff maintained that this had been probable only. We were unable to determine what had been said at the time in question but found that the medical records made reference to a probable diagnosis of MS. The advice highlighted that Ms A was referred to neurology following discussion with the neurology department which is based at another NHS board. No delay in referral was identified and the board had no control over waiting times for appointments, given that the service is provided out with their area. We did make a recommendation around communication as we found that there were a number of differences between the board's and Ms A's understanding.

Although we found that the board's response to Ms A's complaint addressed the points raised, a failing in the board's investigation was identified. We found that a member of staff that had been present when Ms A was advised of the outcome of the medical investigations had not provided comments before the final decision was issued. While this did not affect the outcome in this case, we considered that the board should have ensured all necessary comments were obtained before reaching a conclusion on the complaints.

Recommendations

We recommended that the board:

- use this case to highlight the importance of clear, effective communication with patients.