SPSO decision report

Case: **201508676, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C complained to us following two admissions to University Hospital Crosshouse with severe abdominal pain and persistent vomiting. She was transferred between several different wards, and was due to have a scan of her abdomen. However, she discharged herself prior to this scan taking place. She was re-admitted five days later for an investigative procedure, but chose to be discharged the following day. She complained that the care and treatment was inadequate, and that she was not given the treatment she needed to resolve her symptoms. She also complained that there was a delay in giving her a scan and she was left in pain by poor practices in relation to the insertion of a cannula and a catheter. She said staff were dismissive of her pain and did not identify her as being at risk of falls. She also said hygiene standards were poor, and medical staff failed to diagnose and treat her appropriately.

We obtained independent nursing and gastroenterology advice. The nursing adviser noted concerns Miss C raised in relation to her care, and also the feedback from the board, which had acknowledged some failings. The adviser considered that it was reasonable that Miss C was not assessed for her falls risk, but noted that she should have been given access to a buzzer. The adviser also acknowledged apparent problems with Miss C's cannula site and catheter, though they did not find any evidence of problems in relation to hygiene.

The gastroenterology adviser did not identify any concerns with Miss C's treatment. The adviser noted that there was no evidence to indicate Miss C had Crohn's disease (a long-term condition that causes inflammation of the lining of the digestive system), as she thought she did.

We considered the evidence available, and were satisfied that there were failings in relation to Miss C's nursing care, but not in relation to her clinical treatment. We also considered the evidence in relation to her moves between wards, and were satisfied that in each case, these were made for appropriate clinical and nursing reasons.

Recommendations

We recommended that the board:

- remind staff of the importance of full documentation in relation to the insertion of catheters, to ensure their safe removal and for infection control.