SPSO decision report

Case: **201508860, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained on behalf of his late father (Mr A). He raised concerns that staff at Dumfries and Galloway Royal Infirmary failed to provide Mr A with appropriate medical treatment and about the board's handling of his complaint.

Mr A attended the hospital for a hernia operation. The operation was performed and Mr A was discharged. However, Mr A became unwell and was readmitted to hospital the same day. Mr A's condition continued to deteriorate and he died some months after the operation. The board conducted a significant adverse event review (SAER) and complaints investigation. These processes identified a number of failings, including an error in the prescription of bisoprolol (a beta-blocker, used to treat high blood pressure) and a failure to review blood tests.

Mr C questioned whether the board had appropriately identified all the issues in Mr A's care and whether they had appropriately taken action to address these failings. In addition to the issues with the medication and the review of blood tests, Mr C raised concerns about monitoring Mr C's fluid levels, attending to his catheter and the actions of the consultant surgeon and anaesthetist prior to and after Mr A's admission, including whether staff should have undertaken the operation. Mr C also raised concerns about the way the board's investigations had been conducted, including the interaction between the two processes and delays in responding to his correspondence.

After receiving independent advice from a consultant in general medicine and a nurse, we upheld Mr C's complaints. We found that the prescription of bisoprolol was unreasonable. We also found the board failed to review Mr C's blood tests. We found the board had subsequently taken appropriate action in relation to these issues. However, we also found there was a lack of specific medical review prior to Mr A's discharge and we were critical of this aspect of Mr A's care. We also found failings in respect of monitoring Mr A and in attending to his catheter. In relation to the decision to proceed with Mr A's operation, we found that Mr A had given his informed consent to the procedure, and as Mr A had capacity to make this decision, it was appropriate to proceed with the operation.

We also found that the board's handling of Mr C's complaint was unreasonable. In particular, we found there was confusion about the interaction between the SAER and the complaints process, which lengthened the process and resulted in significant errors in communication with Mr C.

Recommendations

We recommended that the board:

- take steps to ensure the clinician responsible for the error in giving Mr A his heart medication is made aware of the findings of this investigation for reflection and learning;
- confirm that the consultant surgeon will discuss this case in their appraisal;
- provide this office with a progress report on the actions taken to address the issues in the case, including catheter care;

- apologise for the clinical failings identified in this investigation;
- take steps to ensure that staff explain to complainants how the SAER and complaints handling processes are being taken forward in each case;
- feed back the findings of the investigation to the relevant staff for reflection and learning; and
- apologise to Mr C for the failures in complaints handling.