SPSO decision report

Case: **201601214, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C raised concerns about the care and treatment the board provided to his late sister (Mrs A) at Wishaw General Hospital. These concerns extended to medical care, nursing care, and communication with Mrs A's family.

Mrs A had previously been involved in a road traffic accident, but had been discharged and was recovering. She attended Wishaw General Hospital after feeling unwell, and was admitted. She deteriorated the next day, but recovered. She experienced a further deterioration approximately ten days later. Her condition did not improve over the following days, and Mrs A died approximately four weeks later.

Mr C raised a number of specific concerns regarding the board's identification of sepsis (a blood infection), their actions regarding providing Mrs A with a cannula (a thin tube inserted into a vein or body cavity to administer medication or drain off fluid), and staff not transferring her to the intensive care unit when her condition deteriorated. He also raised concerns about nursing care, including management of Mrs A's wounds by nursing staff.

We took independent advice from a consultant in acute medicine and from a nursing adviser. Regarding medical care, we found that Mrs A should have been treated more aggressively for sepsis, and that there was some delay in relation to a cannula. We also found that Mrs A had been given a penicillin based antibiotic, though she was recorded as having an allergy. However, there was no evidence in the record that this impacted on her outcome. Regarding nursing care, we had concerns about wound care, and the general condition of the nursing records. Regarding communication with Mrs A's family, we found there was insufficient evidence of this in the records, given the seriousness of Mrs A's condition.

We upheld Mr C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failings in medical and nursing care provided to Mrs A, and for the poor level of communication with her family. This apology should comply with SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance

What we said should change to put things right in future:

- Staff should be aware of the recognition and management of sepsis.
- Staff should be confident in managing situations where vascular access becomes difficult.
- The microbiology or infection team could be involved in the management of complex cases.
- Staff should communicate adequately with a patient's family and should make sure that communication

with the family is appropriately documented.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.