SPSO decision report

Case: **201601344, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C, who is a solicitor, complained on behalf of his client (Mrs B) about the care and treatment provided to Mrs B's late brother (Mr A) during three admissions to Monklands Hospital in the months leading up to his death. Mr A suffered from alcohol liver disease and hepatic encephalopathy (a deterioration of brain function due to liver failure). Mr C complained that the medical care and treatment provided to Mr A was not of a reasonable standard, that the nursing care was unreasonable, that the communication with the family was poor and that the board failed to adequately investigate and respond to complaints.

Regarding medical care and treatment, the family were particularly concerned that Mr A had been discharged following his second admission when they felt he was not medically fit to be discharged. We took independent advice from a consultant physician and from a senior nurse. We found that Mr A's fitness was appropriately assessed at that time. We also found that, while on the whole Mr A received a reasonable standard of care and treatment, there were some failings in medical care and record-keeping. Specifically, we noted that a final discharge summary was not completed following Mr A's first admission, and that the actual date of discharge was not clear from the notes. We also found that, when Mr A suffered a fall overnight, he was not reviewed by a doctor until the following afternoon. The advice we received was that this review should have happened in the morning. We were also critical that, when this review did take place, the doctor who reviewed Mr A failed to document this assessment. The family had also expressed concerns about Mr A's weight loss and the board had said that this was due to deliberate fluid loss. Whilst we found that deliberate fluid loss was a factor, we considered that there was also a nutritional element that should have been acted upon sooner. In light of these failings, we upheld Mr C's complaint about medical care and treatment.

Mr C raised several concerns about the nursing care and treatment provided to Mr A. We identified that nursing staff had failed to make medical staff aware of a vomiting episode on the morning of Mr A's discharge following his second admission which, had it been shared, may have influenced the medical staff's thinking when assessing Mr A's fitness for discharge. However, we found that this appeared to be an isolated failing, which the board had already acknowledged and apologised for. The family had also been concerned that an appropriate package of home care was not in place for Mr A following his second discharge. We found that adequate arrangements were made, and we noted that responsibility for the delivery of these arrangements lay with social services and not the board. We did not uphold Mr C's complaint about nursing care.

In terms of communication, we found inconsistencies and a lack of clarity in the information conveyed to the family about the seriousness of Mr A's condition. We found that the language used may not have helped the family to fully understand that Mr A's illness was terminal. The family had also raised concerns that their repeated requests to speak to another consultant were not actioned. The board had noted that these requests did not appear to have been passed on, and they had agreed to implement a process to document requests for meetings with medical staff in the future. Overall, we concluded that the communication with the family was not of a reasonable standard and we upheld this complaint.

In relation to complaints handling, we considered that the board could have responded in more detail and could have provided clearer explanations in some instances. However, given the complexity of the complaint and the significant number of issues raised, we were satisfied that, on the whole, the board's response was reasonable and proportionate, and that considerable time and effort had been spent attempting to address the family's concerns. On balance, we did not uphold this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A's family for the identified failings in relation to medical care and treatment, medical record-keeping and communication.

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

- Patient discharge dates should be clearly recorded in the clinical notes.
- Medical reviews should take place within a reasonable timeframe following patient falls.
- Medical reviews should be documented in patient records.
- Medical staff should ensure they remain aware of patients' nutritional status and take appropriate action to address any identified malnutrition.
- Consistent information should be provided, and clear language should be used, when communicating with patients and their relatives regarding the patient's condition and prognosis.

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.