SPSO decision report

Case: **201602391, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the care and treatment provided to her late father (Mr A). Mr A attended the board's out-of-hours service at Monklands Hospital with throat pain and difficulty swallowing. He was seen by an out-of-hours nurse practitioner and an out-of-hours GP. An examination was performed and Mr A was not admitted at that time. Mr A's condition worsened the next day and he was admitted to the hospital where staff identified an abscess in his throat. Over the following days, Mr A had a number of operations and spent time in the intensive care unit (ICU). He was then discharged to the ear, nose and throat (ENT) ward. While on the ENT ward, Mr A suffered a pulmonary embolism (a clot in the blood vessel that transports blood from the heart to the lungs) and died.

Miss C complained that the board's staff failed to appropriately admit Mr A to hospital when he attended the out-of-hours service, that they inappropriately discharged him from the ICU to the ENT ward, and that they failed to appropriately monitor him on the ENT ward. The board considered that Mr A had been provided with reasonable care and treatment by the out-of-hours service, and that he had been reasonably discharged from the ICU. However, they acknowledged that there had been some failures in their clinical observation policy on the ENT ward.

After obtaining independent advice from out-of-hours practitioners, we did not uphold Miss C's complaint about Mr A not being admitted to hospital. We found that there was evidence of an appropriate examination being made, and a reasonable basis for concluding that the problems Mr A was experiencing were due to tonsillitis. We found that it was reasonable for staff not to have admitted Mr A to hospital at that time.

We obtained independent advice from an intensive care specialist regarding Miss C's complaint about the decision to discharge Mr A from the ICU. We found that this decision was consistent with the relevant guidance and adhered to the standards of general practice. Therefore, we did not uphold Miss C's complaint in this regard.

We obtained independent nursing and medical advice regarding the monitoring of Mr A on the ENT ward. We found failings by nursing staff in following the board's clinical observation policy to act on Mr A's deteriorating early warning scores. We found that on one day, Mr A did not receive a dose of medication given to help prevent the development of deep vein thrombosis and pulmonary embolism. However, we did not find that Mr A's outcome would likely have been any different if he had received this medication. On balance, we upheld Miss C's complaint about how Mr A was monitored on the ENT ward.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C and to Mr A's family for the failings in medical and nursing care. The 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, and follow, the board's clinical observation policy, which requires them to act on deterioration when alerted by early warning scores.
- The circumstances of this case should be fully considered for wider learning (for example by discussing the case at a mortality and morbidity meeting).
- Patients should receive appropriate preventative medication for deep vein thrombosis, and this should be reflected in the relevant records.

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.