SPSO decision report

Case: **201602709, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment his late wife (Mrs A) received while she was a patient in Wishaw General Hospital. Mr C was concerned about both the medical and nursing care Mrs A received, and about the way that the board handled his complaint.

In regards to Mrs A's medical treatment, Mr C questioned the length of time a central line (a tube placed by needle into a large, central vein of the body to administer drugs or take blood samples) was in place. Mr C also complained that there was an unreasonable delay by medical staff in reviewing blood test results, and subsequently in Mrs A receiving antibiotics. Mr C believed that, because of poor treatment, Mrs A was denied the opportunity of starting chemotherapy treatment.

We took independent advice from a consultant general surgeon with experience in oncology (cancer treatment) We found that, following Mrs A's admission surgery and further investigations being carried out, it was confirmed that she had extensive, incurable cancer and all further treatment was to be palliative (end of life care). We considered that the length of time Mrs A's central line was in place and the actions of medical staff in prioritising the alleviation of Mrs A's severe pain was reasonable. However, we found that there was a significant delay of several hours in reviewing Mrs A's blood test results and starting appropriate antibiotics. While we found that it was unlikely that the delay in starting antibiotics significantly changed Mrs A's outcome, given her underlying condition and poor prognosis, the delay was unacceptable. Therefore, we upheld this aspect of Mr C's complaint. The board had already acknowledged that there was an unacceptable delay, due to a breakdown in communication involving both junior and senior doctors, and had noted that this has been addressed with staff.

In relation to Mrs A's nursing care, Mr C was concerned over elements of record- keeping and the frequency and recording of some of Mrs A's observations by nursing staff. We took independent advice from a nurse. We found that certain aspects of Mrs A's nursing care were good however, both advisers noted failings in the quality of the completion of some of Mrs A's records and in the frequency of her observations. Therefore, we upheld this aspect of Mr C's complaint. The board had already acknowledged that these issues were unacceptable and noted that they had apologised and taken action.

Finally, Mr C was dissatisfied with the board's response to the concerns he and his family raised about Mrs A's care and treatment. In relation to a meeting which was held to discuss Mr C's concerns, we identified certain aspects that we found to be unreasonable. For this reason, we considered that the board had not responded reasonably to Mr C's complaint. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and his family for the failings identified including a breakdown in communication causing a significant delay in reviewing Mrs A's blood test results and starting appropriate antibiotics

failings by nursing staff in record keeping; and a failure to respond to concerns raised by Mr C and his family following a meeting. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Current practices and processes and the working relationship between junior and senior doctors should be improved to minimise the risk of a future similar event occurring. Ensure that the importance of effective handover is emphasised as part of a junior doctor's induction. Ensure appropriate timescales are in place for requesting, performing and documenting results, and actions taken, for investigations such as blood tests.
- Nursing observations should be carried out in line with the board's Medical Early Warning flowchart and the scoring system should be accurately applied. Nursing care charts and care bundles should be completed accurately and in line with the Nursing and Midwifery Council's guidance on record-keeping. The board should reissue relevant staff with their central line care policy and provide appropriate education to staff to support this. Also, senior nurses should routinely audit compliance with the central line maintenance bundle.

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.