SPSO decision report

Case: **201606048, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment given to his grandmother (Mrs A), both at home and at Monklands Hospital, in the days prior to her death. He said that while Mrs A was at home, staff changed her opiate-based medication. He believed that Mrs A suffered withdrawal symptoms causing her to fall and he was unhappy that she had been persuaded to go to hospital when she had a long-standing wish to remain at home. He said that there was confusion after Mrs A's admittance and that her family were not kept informed of either her whereabouts or her condition. Mr C said that when the family were reunited with Mrs A, she was very distressed and wanted to go home. He said that the family were not told about Mrs A needing an ECG (electrocardiogram - a test to check the heart's rhythm), which caused her further distress. Following this ECG, and at the end of visiting time, Mrs A's family were asked to leave. Mrs A's condition deteriorated rapidly and she died. Mr C complained that he was not advised of the seriousness of his grandmother's condition and that her resuscitation status should have been discussed. He said the family were totally unprepared for her death and he was upset that Mrs A had died alone.

He complained to the board who acknowledged failures in communication but said that Mrs A's deterioration and death had not been anticipated. They explained the reasons why her resuscitation status had not been discussed and added that since Mr C's complaint, Mrs A's case had been discussed with staff and changes had been made to avoid a repetition of the situation for other patients under the board's care in future. Mr C remained dissatisfied and complained to us.

We took independent advice from a nursing adviser and from a consultant geriatrician. We found that the opiate-based medication Mrs A had been prescribed at home for her pain could have side effects, particularly leading to the increased risk of a fall. Her medication had been given a detailed review and changed in view of her presenting symptoms. While Mrs A's fall required her to be admitted to hospital, we found that this was more likely due to her slow heart rate and swollen legs rather than to her change in medication. We did not uphold the aspect of Mr C's complaint regarding changes to Mrs A's medication.

We found that Mrs A's resuscitation status was not discussed with her or her family at the hospital, although there was evidence that they had been ready to talk about it. We upheld Mr C's complaints about the failure to discuss resuscitation status and keep the family updated, and the failure to reasonably take account of Mrs A's wishes regarding this. However, we found that there was no indication that Mrs A was close to death, and that she was being actively treated for her slow heart rate which is considered to be a reversible condition. As such, we did not uphold Mr C's complaint about the board failing to recognise deterioration in Mrs A's condition.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to listen to the family when they were ready to talk about resuscitation. 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 reminded to inform family members about what is happening to their relatives.

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.