SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201608381, Lanarkshire NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment she received at Wishaw General Hospital. Her concerns included that the consultant failed to initially list her for a colonoscopy (examination of the bowel with a camera on a flexible tube) as intended, and she was subsequently listed for a gastroscopy (examination of the gullet and stomach with thin, flexible telescope) in error. Ms C said that this error was not identified until the day of the procedure, despite her having called up in advance to query it. She said that the consultant did not contact her at any stage with an explanation of her results or treatment plan. Ms C also said that the consultant discharged her from their care as a result of her having submitted a complaint to the board. Although Ms C was later advised that they would arrange for one of their colleagues to see her instead, she heard nothing further.

We took independent advice from a consultant gastroenterologist (a doctor who specialises in the digestive system). We found that the board failed to list Ms C for a colonoscopy and later listed her for a gastroscopy in error. We also found that this error was not identified until the day of the procedure. We noted that a letter from the consultant to Ms C, requesting a stool sample, failed to explain the reasoning behind the request and inform Ms C of the findings and of a further management plan.

We also found that the consultant unreasonably discharged Ms C from their care and failed to ensure safe transfer of the necessary information on her case to a colleague, in line with the correct guidelines. We considered that the board then failed to take appropriate action when this was raised with them. Therefore, we found that the care and treatment Ms C received was unreasonable and upheld her complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for sending a letter requesting a stool sample that contained inadequate information; unreasonably discharging her from their care; and failing to ensure safe transfer of the necessary information on her case to a colleague.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:

- Patients should be accurately listed for endoscopic procedures and the steps for this process documented. Phone contact by patients about listed procedures should be documented, tracked, and where appropriate, acted on.
- Essential patient information on care and treatment should be provided to the patient. Patients should be discharged from care in line with the correct guidelines. Patients should have the safe transfer of the necessary information on their case to another consultant.

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.