SPSO decision report

Case: **201701880, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained on behalf of her husband (Mr A) about the care and treatment he received at Dumfries and Galloway Royal Infirmary. Mr A became unwell and was admitted to hospital. A heart scan identified that he had a gathering of fluid around his heart. Staff inserted a chest drain (a tube to remove fluid) but the next day staff discovered that the drain had become blocked. They made multiple unsuccessful attempts to insert another chest drain which resulted in significant bleeding. A decision was made to transfer Mr A to a hospital out with the board, which took place late in the evening.

Mrs C complained that the board failed to provide Mr A with appropriate medical care and treatment. She raised particular concerns about the actions of the staff in inserting chest drains and about the time taken to transfer Mr A to the other hospital. Mrs C also complained that the board failed to communicate appropriately regarding Mr A's condition.

We took independent advice from a consultant cardiologist. We found that bleeding is a recognised complication of the chest drain procedure and that it appeared reasonable. However, we found that records showed evidence of poor communication between staff and concerns about skills in relation to some members of staff. Regarding the transfer of hospitals, we found that the time taken to transfer Mr A to the hospital outside the board was unreasonable. We also found that the discharge arrangements were inadequate, given the complicated nature of Mr A's admission. Therefore, we upheld this aspect of Mrs C's complaint.

In relation to communication with Mrs C, we found that there was evidence of poor and limited communication with both her and Mr A, particularly surrounding the procedure to insert the chest drain and the transfer of hospitals. We upheld this aspect of Mrs C's complaint. However, we noted that the board had taken action to address a number of these problems.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A and his family for the failings in care, discharge arrangements and communication. 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:

- In similar cases, consideration should be given to ensuring appropriate out-patient follow-up on discharge.

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.