SPSO decision report

Case: **201703321, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment his late father (Mr A) received during his two admission to Wishaw General Hospital. Mr A was diagnosed with bowel cancer and Mr C complained that the board failed to provide Mr A with appropriate medical and nursing care and treatment.

We took independent advice from a consultant in acute medicine, a consultant in colorectal surgery (a specialist in disorders of the rectum, anus and colon) and a nurse. In respect of Mr A's first admission, we considered that Mr A's underlying issues were all reasonably investigated, treated and resolved. In respect of Mr A's second admission, we found that all appropriate investigations were carried out and that, overall, Mr A received appropriate medical treatment. However, we noted that there was an unreasonable delay before Mr A was seen by the speech and language therapy service (SALT) given that there was concerns regarding his ability to swallow. Therefore, we upheld this aspect of Mr C's complaint.

In relation to the nursing care, we found that there was no evidence to indicate any failings in nursing care and that the nursing records were of a reasonable standard. We did not uphold this aspect of Mr C's complaint.

Mr C also complained that the board failed to communicate appropriately with Mr A's family regarding his condition at a meeting. In particular, that only two family members were allowed to attend the meeting when there were twice as many hospital staff in attendance and that he was not allowed to record the meeting. We considered it was unreasonable that Mr C had been restricted to two family members while double the number of hospital staff attended the meeting. Mr C also appeared to have been open with hospital staff that he wanted to record the meeting and the reason for this. Therefore, we considered it would have been reasonable to have allowed him to record the meeting. We upheld this aspect of Mr C's complaint. We also noted that that these issues could have been avoided if the board had a policy that ensured both parties were aware of the ground rules for such meetings in advance. We made a recommendation to the board in light of this finding.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the unreasonable delay by hospital staff in referring Mr A to SALT, for restricting the number of family members who were permitted to attend the meeting and not allowing the meeting to be recorded. 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 with impaired ability to swallow should receive an appropriate and timely referral to SALT.
- Both staff and patients and/or their families should be clear about what to expect in advance of a meeting.