SPSO decision report

Case: **201703486, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment her late son (Mr A) received when he was admitted to the Western General Hospital. Mr A had duchenne muscular dystrophy (a genetic disorder characterised by progressive muscle degeneration and weakness) and an associated heart condition and was admitted to the hospital with abdominal pain and swelling. He died in the hospital a week after he was admitted.

We took independent advice from a consultant general surgeon and a nurse. We found that it had been reasonable to admit Mr A to a surgical ward. He was examined by a surgical registrar and the on-call medical registrar which was an example of good care. However, we found that there had been a number of failings in the care and treatment provided to Mr A. In particular that:

• he should have been treated by a multi-disciplinary group of consultants, including a cardiologist (a doctor who specialises in the study or treatment of heart diseases and heart abnormalities);

• it was unreasonable for a consultant from the hospital's ventilation service not to take appropriate steps to evaluate Mr A when they were informed of his admission;

• it was unreasonable not to record Mr A's fluid intake/output;

• staff failed to act appropriately on an abnormal CT scan;

• staff unreasonably failed to reconsider the diagnosis of kidney infection;

• it was unreasonable for a junior doctor to propose discharging him;

• communication between general surgery and urology (the branch of medicine and physiology concerned with the function and disorders of the urinary system) was poor;

• no moving and handling assessment was carried out when Mr A was admitted to hospital; and

• no equipment was available for the safe movement and transfer of Mr A three days after he was admitted to hospital.

We upheld Mrs C's complaint about the care and treatment provided to Mr A, however, we found that it was highly likely that the outcome would have been the same for Mr A if these failings had not occurred.

Mrs C also complained that the communication with her family had been unreasonable. We found that whilst there was evidence of discussions with the family and of staff responding to their concerns, Mr A had complex needs and the family should have been involved in his care in a planned and collaborative way. There was no evidence

of this. We found that there had been a lack of appropriate engagement with the family in the assessment and care planning for Mr A and that the communication with his family had been poor. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide Mr A with reasonable care and treatment in the hospital and for the poor communication with her family. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leafletsand-guidance.

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

- The board should ensure that appropriate multi-disciplinary management is triggered when a deteriorating adult with duchenne muscular dystrophy is admitted to hospital.
- Patients identified as being at risk should have their fluid intake and output accurately monitored.
- The board should ensure that CT scans are acted on appropriately and that the diagnosis is reconsidered in the light of any new findings.
- Patients should be appropriately reviewed and discussed with a relevant member of staff before discharge is proposed.