SPSO decision report

Case: **201704104, Dumfries and Galloway NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to him during two admissions at Dumfries and Galloway Royal Infirmary.

Mr C had Hodgkin's Lymphoma (a cancer of the lymphatic system, which is part of the immune system). Mr C complained that he should not have been discharged after he felt unwell during an admission for a blood transfusion. We took independent advice from a consultant haematologist (a doctor who specialises in blood). We found that the follow-up arrangements made prior to discharge were unreasonable. We, therefore, upheld this part of Mr C's complaint.

During a subsequent admission, Mr C experienced a build-up of fluid in the lining of his lungs. He complained that there was a delay in carrying out a procedure to drain the fluid. We found that medical staff appropriately monitored whether a drain was needed to improve Mr C's symptoms and we did not consider that there was an unreasonable delay. We did not uphold this aspect of the complaint.

Mr C also experienced a build-up of fluid around his heart which required a procedure (pericardiocentesis) to drain the fluid. Mr C complained that the two attempts to carry out this procedure were not of a reasonable standard. We found that the first attempt was halted after Mr C became uncomfortable. The second attempt was stopped after concern was raised that Mr C's heart was damaged. Mr C was then transferred for emergency assessment, where the procedure was carried out successfully and no significant damage to Mr C's heart was identified.

We took independent advice on this from a consultant cardiologist (a doctor who specialises in the heart and blood vessels). We found that the first attempt at pericardiocentesis was not performed to a reasonable standard and was not documented adequately. However, we found that the board had carried out an internal investigation and that the operator involved had since reflected on what had happened and identified learning points. Despite the complication, we were not critical of the second attempt at the procedure as we found that staff took appropriate action once it was apparent that Mr C's heart had potentially sustained damage. On balance, we upheld this aspect of the complaint.

Lastly, Mr C complained about the level of communication with him during his second admission. We found that haematology staff did not update Mr C about the overall picture frequently enough, which may have added to his anxiety about his situation. We noted that Mr C had not been informed of the small risk of death prior to the attempts at pericardiocentesis. We upheld this part of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C that they did not make sufficient follow-up arrangements prior to discharge; did not adequately explain the risks of pericardiocentesis; and did not communicate with Mr C frequently enough

during his second admission. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Patients should be aware of what to do if they become unwell after discharge and how to contact the haematology department for advice. Patients with low blood cell count should be carefully monitored for changes in blood cell count.
- The approach and technique used in invasive procedures should be adequately documented in a patient's clinical records.
- Patients should be fully informed of the recognised risks, including death, as part of the consenting process prior to performing pericardiocentesis.
- Patients should receive the information they want or need to know in a way they can understand.