SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201705076, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained on behalf of her client (Ms B) about the care and treatment provided to Ms B's late father (Mr A). Mr A suffered from heart problems and had a history of diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired) and a previous stroke. Over a period of about 18 months he had several hospital admissions and underwent two cardiac catheterisation procedures (where a tube is inserted into a blood vessel near the heart, to look at the condition of the blood vessels and/or insert a stent to widen them), but no stent was inserted. Doctors then referred Mr A for consideration of coronary bypass surgery (surgery to bypass a section of existing blood vessel that is narrowed with a graft). However, while he was waiting for review, Mr A suffered a further stroke and heart attack, and he died in hospital a few weeks after this. Mr A's family felt he should have been offered surgery earlier. They also raised concerns about the medical and nursing care during his admissions, and the board's response to their complaint.

The board considered the medical care and communication was reasonable. However, they agreed there were some failings in the nursing care for Mr A's pressure ulcers and they apologised for this and took action to prevent a recurrence.

We took independent medical, cardiology and nursing advice. We found that the overall management of Mr A's heart problems was reasonable, and it was appropriate that surgery was not offered earlier as this would have been a very high risk for Mr A (in view of his pre-existing conditions). We did not uphold this aspect of Mrs C's complaint. However, we found that there was no evidence Mr A or his family were told about Mr A's heart attack for several days, and we made a recommendation in light of this finding.

We upheld the complaint about nursing care, as we found failings in relation to fluid monitoring, pressure ulcers, falls monitoring and communication with the family about Mr A's palliative care.

We also upheld the complaint about complaints handling, as there were errors in the board's complaint response, which appeared to be due to the medical records being misread.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A's family for the delay in informing them about the heart attack, the failings in nursing care and communication, and the errors in the complaint response. 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 and/or family should be promptly updated about significant events, such as a heart attack, and a record made of the communication.

- Good palliative care should ensure a comfortable and peaceful time for the patients, with support for relevant others and person-centred communication.
- There should be clear handover communication between staff, to ensure all staff are aware of a patient's needs.
- Fluid balance charts should be completed for patients requiring fluid restriction.

In relation to complaints handling, we recommended:

- Complaint investigations should involve a careful and thorough review of the medical records, having particular regard to the points of complaint raised.