SPSO decision report

Case: **201707729, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late relative (A). A had surgery for a fractured hip and wrist at Hairmyres Hospital. At a clinic appointment a few weeks later, A was advised that there was an issue with a screw being close to the joint in their hip. A was not keen on further surgery and there was an agreement to review them again in six weeks. Subsequently, A's pain increased and their mobility decreased. An x-ray showed that the screw had failed; therefore, surgical correction was considered and further surgery was subsequently performed. A's clinical condition deteriorated and they died a number of weeks later. C complained to the board about A's care and treatment. The board responded to the complaint and carried out a review of A's care. The board identified some evidence of poor care.

C remained unhappy and complained to us about A's care and treatment and the board's handling of their complaint. We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly) and from a trauma and orthopaedic (a specialist in the treatment of diseases and injuries of the musculoskeletal system) consultant. We found that A was appropriately reviewed by medical staff and that there was no evidence of a delay in A's pain being identified following their first operation.

However, we identified that medication errors in relation to the prescription of vitamin D had occurred which were significant. Whilst we did not find evidence that the errors caused harm to A, the errors had not been appropriately documented in the medical records when they were identified; nor were they reported on the second occasion as they should have been. A and their family were also not informed about the medication errors at the time, contrary to General Medical Council (GMC) guidance. We were critical that the board's review of A's care did not take sufficient action to adequately address these errors.

We also found that, when A consented to further surgery (which was major and complex), there was no evidence to show that the option of a girdlestone procedure (removal of the metal work only which would have left A with a significant functional disability) had been discussed with A or their family. We considered that this was unreasonable and contrary to national guidance on consent.

We upheld the complaint on the basis that there was a missed opportunity for the board's review to adequately address failings in care and to fully learn from these events.

We also found that there were failings in the board's handling of C's complaint in that there was an unreasonable delay in investigating and C receiving their final response. We also considered that the board's response was inadequate in that it failed to identify and address the potentially serious medication errors that occurred. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to appropriately prescribe vitamin D; document and report the medication errors when they were identified; inform A and the family at the time; take sufficient action to address the errors when they were identified in the board's review; discuss the option of a girdlestone procedure; and handle C's complaint adequately. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients should be fully advised of all relevant surgical options and the discussion should be clearly recorded, in accordance with relevant standards and guidance.
- Any reviews undertaken should sufficiently address any errors/failings identified.
- Medication should be prescribed safely. Medication errors should be appropriately documented in the medical records when they are identified and reported by the board's reporting system. Patients and their relatives should also be appropriately informed in line with GMC guidance.

In relation to complaints handling, we recommended:

- Complaints should be handled in line with the board's and NHS Model Complaints Handling Procedure.

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.