SPSO decision report

Case: **201708315, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment his mother (Mrs A) received at Lorn and Islands Hospital. Mrs A initially presented to the emergency department experiencing vomiting. Following assessment, Mrs A received antibiotics and was discharged home. Mrs A returned to the emergency department two days later again with vomiting symptoms. After further assessment was carried out, Mrs A was discharged home. Mrs A attended the hospital again approximately five days later and was admitted to a ward. During the admission, investigations were carried out which indicated that Mrs A had metastatic cancer (cancer that has spread to other parts of the body). Mrs A's condition deteriorated during the admission and she died from her illness. Mr C complained about the care and treatment his mother received as well as the way hospital staff communicated with the family.

We took independent advice from a consultant in general medicine and a registered nurse. We found that Mrs A was unreasonably discharged from the emergency department on two occasions without her symptoms being effectively managed. We also found that an incorrect diagnosis had been reached during the first presentation to the emergency department, whilst the second presentation was poorly documented. We noted that once Mrs A was admitted to the ward, there was an unreasonable delay in obtaining a CT scan (a scan that uses x-rays to create detailed images of the inside of the body) of Mrs A's chest/ abdomen. We upheld this aspect of Mr C's complaint.

In response to Mr C's complaint, the board apologised that inaccurate information was given to family members regarding the length of time to obtain test results. We also found that there was a lack of discussion between nurses, doctors and the family around the possibility of discharging Mrs A home and a lack of clarity with the family about this. We upheld this aspect of Mr C's complaint.

Finally, Mr C was also unhappy with the time that the board took to investigate and respond to his complaint. We found that the delay was unreasonable and we were critical of the board's communication surrounding the delay. We upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should apologise to Mr C for the unreasonable decisions to discharge Mrs A on two occasions; the incorrect diagnosis of urinary tract infection; poor documentation of Mrs A's second hospital attendance; the unreasonable delay obtaining a chest/ abdomen CT; the lack of local multidisciplinary discussion around the possibility of discharge; and failing to provide a reason for the complaint handling delay and a revised timescale. 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:

- Clinicians should take time to observe whether a patient requiring anti-sickness medication needs this medication to be given from a route other than oral, or needs alternative anti-sickness medication to manage their symptoms.
- A diagnosis of urinary tract infection should be supported by presence of relevant symptoms and appropriate tests.
- Patient records should include documentation of a full assessment by the medical team; details of any subsequent discussions; and plans for follow-up.
- CT imaging should be performed timeously.
- Patients and families should receive realistic estimates for how long it will take for biopsy results to become available.
- Where possible, patients with a life limiting diagnosis and their families should be involved in discussions around their preferred place of end of life care and what would be required to facilitate this.

In relation to complaints handling, we recommended:

- Where the complaint investigation cannot be completed within 20 working days, the person making the complaint should be provided with an explanation for the delay and a revised timetable for the response.