SPSO decision report

Case: **201800428, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained that his wife (Mrs A) had undergone open heart surgery at Edinburgh Royal Infirmary when she had been due to undergo a less invasive procedure. Following surgery, Mrs A was transferred to another hospital where she died shortly afterwards. Mr C said that his wife suffered from dementia and could not have understood the decision to change the procedure or have provided informed consent. Mr C noted he had welfare power of attorney and accompanied his wife to all her appointments. Mr C said that he had not been informed about the change of procedure. Mr C also complained that Mrs A was unreasonably discharged to another hospital. Mr C felt that Mrs A would have survived if she had been treated differently.

We took independent medical advice from a consultant cardiothoracic surgeon (a specialist who operates on the heart, lungs and other chest organs). We found that Mrs A's procedure was changed after an appropriate assessment of the risks of both types of surgical procedure and that it was reasonable to proceed with open heart surgery. There was no evidence that Mrs A's chances of survival were compromised by this decision. We also found that an assessment had been carried out which found that Mrs A had a mild memory impairment, however, medical staff were satisfied that she had the capacity to understand and consent to the change in procedure. We considered that this was reasonable. Therefore, we did not uphold these aspects of Mr C's complaint.

In relation to the hospital transfer, we found that this was unreasonable given Mrs A's condition. We upheld this aspect of Mr C's complaint. However, we could not determine that Mrs A would have survived if this had not taken place.

In relation to the board's communication with Mr C and his family, we found that Mrs A had been in hospital for over a week prior to the procedure due to a chest infection and that Mr C had been present every day. We considered that the board should have discussed Mrs A's care when Mr C was present. Therefore, we upheld this aspect of Mr C's complaint. We noted that the board had acknowledged and apologised for this failing.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for unreasonably deciding to transfer Mrs A to another hospital before she had sufficiently recovered from surgery. 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:

- Review their policies and procedures for patient transfer to ensure that distance travelled is taken into account as part of the decision.