# SPSO decision report

**Case:** **201800660, Lanarkshire NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

Mr C complained about the care and treatment provided to his late father (Mr A) when he was admitted to Hairmyres Hospital with a suspected chest infection. Mr A was fed via a Percutaneous Endoscopic Gastrostomy (PEG, a tube into the patients's stomach through the abdominal wall) and early in the morning, on the day after his admission, Mr A's PEG became detached. While it appeared that nurses noticed this, it was not reported until a ward round later that day. By then, the entry tract had closed and the feeding tube was unable to be reinserted.

Subsequently, there were difficulties in ensuring Mr A's nutrition and there were numerous failed attempts to re-establish his feeding. After ten days, Mr A's family requested that he be transferred to another hospital to have a PEG surgically inserted but the procedure had to be stopped. Mr A died shortly afterwards. Mr C complained that staff failed to act when the PEG had become detached.

We took independent advice from a consultant in general medicine. We found that the board's guidance stated that if a gastronomy feeding tube fell out, it should be replaced as soon as practicable, preferably within two hours. However, this did not happen and staff were initially unaware of the need to reinstate the PEG within a particular time frame. We also found that there was a lack of coordination and planning around the repeated failure to obtain a consistent route of feeding and there was a lack of communication about how unwell Mr A was. Although the outcome for Mr A may have been the same, we considered that his recovery was compromised by a level of care that fell below what could have been expected. Therefore, we upheld Mr C's complaint.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failure to provide Mr A with a reasonable level of care in that his PEG tube was not quickly replaced and that there was a failure to initiate alternative methods of feeding. 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:

- Staff should be aware of and adhere to the board's policy on Enteral Tube Feeding, Best Practice Statement for Adults. Patients in a similar situation should receive a timely and feeding regime commenced and timely consideration of transfer. Record-keeping by doctors should meet General Medical Council standards.