SPSO decision report

Case: **201801873, Lothian NHS Board - Acute Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained on behalf of his wife (Mrs A) about the care and treatment she received at Western General Hospital. Mrs A was admitted to the surgical assessment unit in the evening with a serious bowel condition. She experienced severe pain in the overnight period whilst she waited to receive surgery. The following morning surgery was successfully performed. Mrs A remained critically unwell for a number of weeks following the procedure.

In response to Mr C's complaint, the board acknowledged that better care could have been provided overnight and the operation should have been performed sooner. Mr C remained concerned about what happened and brought his complaint to us.

We took independent advice from a colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus), a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques) and a registered nurse. We identified a number of issues with the care and treatment provided to Mrs A in the overnight period. In particular, we found that the CT scan performed was not reported accurately as it failed to mention the radiological evidence of mesenteric ischemia (a serious condition involving sudden interruption of the blood supply to a segment of the small intestine). We also found that the medical review and nursing monitoring in the period under consideration were unreasonable, and we noted issues with record-keeping.

We also found that nursing and medical staff had failed to escalate matters to senior medical staff when this would have been appropriate. Finally, and in line with the board's findings, we found that there was an unreasonable delay in transferring Mrs A to theatre for emergency surgery. We considered that earlier surgery would not have impacted on the extent of surgery required, but might have mitigated the severity of Mrs A's critical illness. We upheld Mr C's complaint and made a number of recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs A and her family for the failings in CT reporting; failings in medical review; failings in nursing record-keeping; and failure to escalate the deterioration. 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:

- CT imaging should be accurately reported. Arrangements for supervision of on-call radiology registrars should conform to Royal College of Radiologists guidelines. The service should be satisfied that they have minimised the contribution of any systems deficiencies to radiological error.
- Nursing records should be maintained in line with the standards required by the Nursing and Midwifery

Council Code.

- Nursing staff should have appropriate expertise and confidence in identifying deteriorating patients and escalating concerns to medical staff.
- Surgical staff should be alert to a patient's clinical condition and respond promptly to contact from medical colleagues.
- Where there is a risk that patient safety may be compromised, prompt action should be taken to escalate the matter to appropriate senior staff.
- The board should have an appropriate pathway in place for emergency laparotomy care.

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.