SPSO decision report

Case: **201803175, Lothian NHS Board - Acute Division**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

Mr C complained on behalf of his partner (Ms A) who had been diagnosed with lung cancer. She also suffered from other illnesses.

Ms A had experienced shortness of breath and fatigue. It was established that she had anaemia and was referred to St John's Hospital for a blood transfusion by the oncology team at another hospital. When Ms A arrived at St John's Hospital there were no beds and before being transferred to the Medical Assessment Unit (MAU) she spent seven hours on a temporary bed in the corridor. She was eventually transferred to MAU and was given a blood transfusion later that night. Later, she was moved to an observation ward and the next day she was discharged home.

A few days later, Ms A was unwell again and she was admitted to St John's Hospital once more. Again, she spent a number of hours in a corridor before being admitted to the MAU. Mr C complained that these events were unacceptable given Ms A's serious illness. The board recognised that the situation had not been ideal but said that on both occasions the hospital had been extremely busy. They apologised but said that they could not give assurances that the same situation would not occur again. They confirmed that Ms A had been treated in accordance with the cancer treatment helpline advice. They added that St John's Hospital had asked the referring hospital whether the transfusion could be deferred the first time Ms A attended hospital but were told that it could not.

We took independent advice from consultants in general medicine and oncology (cancer). We found that although the board had no control over the number of patients arriving at the same time, it was, nevertheless, unreasonable that a cancer patient like Ms A should have had to wait so long (seven hours each time) before being transferred to MAU. We also found that there was no clinical reason why Ms A should have been given a blood transfusion late at night. For these reasons we upheld the complaint. Although Mr C had also complained about the cancer treatment helpline, this was a national helpline run by another public body and the board could not be held responsible for the policy of another organisation.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms A for the time required to wait before transferred to MAU. The apology should meet the standards set out in the SPSO guidelines on apologyavailable at www.spso.org.uk/information-leaflets.
- Apologise to Ms A for giving a blood transfusion late at night when there was no urgent requirement to do so. The apologies should meet the standards set out in the SPSO guidelines on apologyavailable at www.spso.org.uk/information-leaflets.

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

- Cancer patients in particular should be admitted to MAU in a timely manner.
- Blood transfusions should be given in line with National Institute for Health and Care in Excellence guidelines.