SPSO decision report

Case: **201806672, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their relative (A) received at Wishaw General Hospital. A had been admitted to hospital in relation to an infection. They developed hospital acquired pneumonia and died days later. C was concerned that the Hospital Emergency Care Team (HECT) did not respond appropriately to A's deteriorating condition, and that that there had been a failure to contact the family when A's condition deteriorated.

In response to the complaint the board acknowledged, in hindsight, that HECT should have reviewed A in person rather than a telephone discussion having taken place between HECT staff and ward staff. The board said that they were unable to say whether or not A's management would have changed, had they been seen by HECT. The board accepted that the family should have been contacted and they apologised for this. Action was also taken to remind staff of the importance of contacting relatives.

We took independent advice from a consultant in geriatric (elderly) and general medicine. We found that when A deteriorated overnight, they should have been seen by HECT. We also considered that A should also have been examined the following morning. A had delayed recognition and treatment of the infection as a result. This reduced A's chances of surviving the infection, but we could not say with certainty that this would have significantly improved the chance of survival. We were also critical that the record-keeping by HECT was not in line with the Nursing and Midwifery Code.

We agreed that the family should have been contacted and recommended further action to be taken by the board for further learning and improvement. We concluded that A did not receive a reasonable level of care in keeping with local and national standards and, therefore, upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings by HECT and for not examining A within a reasonable time. 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:

- Deteriorating patients should be reviewed in accordance with local and national guidance and this should be appropriately recorded in line with the Nursing and Midwifery Code.

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.