SPSO decision report

Case: **201900907, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, an advice and support service worker, complained on behalf of their client (A) regarding care and treatment A received from the board. A presented to University Hospital Monklands with abdominal pain, which had been treated as a urinary infection. It was thought that the symptoms were related to their kidneys. A had a scan days later and as a result was diagnosed as having a twisted right ovarian cyst which required surgery. C complained that there had been a misdiagnosis and delay in carrying out a scan. They questioned whether the ovary would not have needed to be removed had the correct diagnosis been made earlier. C also complained that A's mobility and pain were not properly assessed, and compression stockings were not provided.

In responding to the complaint, the board apologised that there had been a breakdown in communication regarding the scan and advised that this would be discussed with the doctor in further detail. In terms of the nursing care provided, the board did not identify any failings.

We took independent advice from a consultant general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus) and from a registered nurse. In terms of the medical care, we found that A's ongoing pain three days after being treated for urine infection was uncommon and that a diagnosis of kidney stones or another cause of pain should have been considered. We considered that a scan should have been carried out on the day it was originally planned and it was unreasonable care that this did not happen. However, we did not consider that A's outcome of undergoing surgery and having an ovary removed would have been affected by the delay in the scan. Nevertheless, we found that the delay resulted in A being in pain for longer and acknowledged that this was distressing for them. We upheld this complaint.

In terms of the nursing care, we found it was reasonable not to have provided A with compression stockings. However, we considered there were failings in a mobility assessment not being carried out, and there was no clear care plan for their persistent and unresolved pain. Had there been so, this may have led to escalation to medical staff; a review of their pain; and expedited some of tests, if it was recognised pain was becoming difficult to manage in the context of an undiagnosed cause. For these reasons, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the following aspects of their care: that there was no differential diagnosis or a plan on management clearly recorded; that there was no medical review of A' pain and observations documented; that there was no explanation about why the original plan for a CT scan was changed to an ultrasound scan and then changed back; that there was a delay in performing a CT scan; and that A's mobility was not reasonably assessed or at least documented. 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:

- Clearer record for pain relief and management is required to accurately assess pain with escalation to medical staff as appropriate.
- Documentation on rounds should provide adequate reflection of clinical examination, review of observations, possible diagnosis, and plan of management.
- Nursing staff should ensure, where relevant, a patient’s mobility is assessed and documented.