SPSO decision report

Case: **201907667, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) by the board. A was admitted to the hospital due to a catheter blockage. On examination, it was determined that A required specialist treatment and an ambulance transfer to another hospital within the board was arranged. It took approximately six hours for the ambulance to arrive by which time A was showing signs of sepsis (a life-threatening reaction to an infection).

Antibiotics treatment was initiated on A's arrival and they had regular washouts of their catheter and continuous irrigation due to blockages and bleeding. A had ongoing uro-sepsis and required blood transfusions. A suffered a heart attack during their admission and blood-thinning medication was prescribed. However, this made the bleeding at the catheter site increase. A died in hospital several days later.

C complained to the board about A's care and treatment but the board did not identify any failings. The board did identify and apologise for failure in communication with C. C remained unhappy and asked us to investigate. C complained that the staff in the first hospital had unreasonably delayed in treating A with antibiotics. C complained that staff in the second hospital subjected A to unnecessary pain while irrigating their catheter. C also complained that staff failed to identify that A's catheter had been incorrectly placed. C complained about a decision to prescribe A with the anti-coagulant. C also complained about the palliative care given to A.

We took independent advice from a consultant in emergency medicine and a consultant urological surgeon (specialist in the male and female urinary tract, and the male reproductive organs). We found that staff in the first hospital had unreasonably delayed in treating A with antibiotics and we upheld this aspect of C's complaint. We found that the care and treatment given to A in the second hospital was reasonable. However, we considered that staff had failed to recognise that A's catheter was in the incorrect position within a reasonable timescale and therefore upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the delay in treating A with antibiotics until they had been transferred to the specialist; and in recognising that A's catheter was in the incorrect position. 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:

- Patients diagnosed with sepsis should have antibiotics administered promptly and without delay.
- Patients undergoing catheter insertion should be closely monitored so that any complications such as incorrect placement are recognised and treated without delay.

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.