SPSO decision report

Case: **202000275, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their relative (A) about the treatment A had received from the board. A had emergency surgery to repair a dissected aorta (a tear in the heart) and was discharged following treatment. A developed an infection in their surgical wound and was readmitted to hospital for further treatment. C complained that in treating A's infection, the board incorrectly administered A with penicillin (an antibiotic) to which they are allergic. Following intravenous Co-Amoxiclav (antibiotic used for bacterial infections), A developed a skin rash. C also complained that A was administered ibuprofen which should not have been prescribed to A due to the heart medication they were taking.

We took independent advice from a clinical adviser. We found that there was no evidence in A's medical records of a penicillin allergy prior to the development of their skin rash following intravenous Co-Amoxiclav. We also found that the board's use of a penicillin derivative was reasonable and an appropriate choice of antibiotic for A's wound infection. We noted that the potential adverse effects of taking ibuprofen did not mean that it could never be used in patients taking A's heart medication. In A's case, the use of ibuprofen postoperatively had not been sufficiently documented, therefore we were not able to determine whether its use was appropriate. On balance, we found that the board had provided a reasonable standard of treatment to A and did not uphold this aspect of C's complaint.

C further complained that the board had not provided A with clear information regarding their cardiology (area of medicine concerning diseases and defects of the heart and blood vessels) rehabilitation and aftercare, resulting in a delay in A receiving appropriate follow-up appointments.

We took independent advice from a cardiologist. We found that the board had not correctly processed A's referrals for cardiology follow-up and cardiac rehabilitation or done so in a timely manner. The board had not correctly identified a discrepancy in A's nutritional assessment scoring or followed this up at the time. Therefore, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and A's family for not correctly processing the referrals for their cardiology follow-up and cardiac rehabilitation, and for providing A with aftercare that fell below a reasonable standard. 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:

- Ensure a process or system is implemented so that discrepancies with patient malnutrition universal screening tool (MUST) scores/nutritional assessments are easily identifiable so that follow-up dietetics

reviews can be requested.
- Ensure appropriate referral pathways are in place to ensure patients receive timely cardiology and cardiac rehabilitation follow-up as noted in a patient's post-surgical discharge summary.

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.