SPSO decision report

Case: **202007141, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) by the board while they were an in-patient at hospital. During A's admission they were diagnosed with stage 4 cancer and COVID-19. A died of COVID-19 in hospital.

C complained to the board about A's care and treatment. C also complained about communication with A's family. The board apologised for aspects of their communication, but did not identify any failings with A's care and treatment. C remained unhappy and asked us to investigate.

C complained about the care and treatment A received for COVID-19 and about the communication A's family received regarding their COVID-19 diagnosis. C complained that the board had failed to adequately investigate the complaint and had failed to adequately investigate how A caught COVID-19.

We took independent advice from a general medicine adviser. We found that aspects of the care A received after their COVID-19 diagnosis, along with aspects of the board's communication with A's family regarding A's COVID-19 diagnosis and treatment were unreasonable. We also found that the board's response to C's complaint contained inaccuracies and that there was a lack of detail. We found that the response failed to adequately address, from a medical perspective, the concerns C had raised, in particular, in relation to A's COVID-19 diagnosis. We upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the failure to provide A with reasonable care and treatment, failure to adequately investigate C's complaint and for failure to communicate adequately with C about A's COVID-19 infection. 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:

- DNACPR forms should be appropriately completed by staff who should ensure its implications are discussed with and fully understood by the patient and/or family members at the time of completion. When a patient tests positive for COVID-19, in particular where they have other serious underlying illnesses, a detailed medical review of the patient should be carried out as soon as possible. The reasons for treatment decisions should be clearly documented on a TEP. Prompt consideration should be given to closing a ward where an outbreak of COVID-19 occurs.
- Patients families should receive clear explanations, and be provided with appropriate information that addresses their concerns when responding to complaints.
- Communication with patients and/or their families should be proactive and timely, especially in relation to a

serious diagnosis. Where discussions have taken place they should be documented.

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.