SPSO decision report

Case: **201102935, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment her late husband (Mr C) received in hospital. Mrs C said that a locum (temporary) assistant had not carried out the correct procedure for referring Mr C to a specialist chest consultant at the hospital; that records from another patient were found in Mr C's notes and that an occupational therapist (OT) had conducted an assessment on Mr C using water from a tap with a blocked sink.

We took independent advice from a medical adviser, who considered all aspects of Mrs C's complaint and Mr C's care at the hospital. He said that the board had failed to ensure that an abnormality on Mr C's chest x-ray was appropriately investigated after it was noted by the radiologist (a medical specialist that uses imaging to diagnose and treat disease). The board had acknowledged and addressed this, and apologised to Mrs C before the complaint was brought to us. We, therefore, upheld this complaint. Mr C subsequently died of cancer, but our adviser said that it was not possible to say whether the outcome for Mr C would have been different had a diagnosis been made earlier.

Although our investigation found no evidence that another patient's records were included in Mr C's notes, we acknowledged that such an event can occasionally occur and noted that the board had expressed regret about this. We upheld the complaint.

We found no evidence that water from a blocked sink had been used in the OT assessment and so we did not uphold this complaint.

Recommendations

We recommended that the board:

- provide an update on the implementation of their protocol, with specific reference to how results of investigations undertaken whilst a patient is an in-patient are reconciled with their case notes after discharge.