SPSO decision report

Case: **201103236, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, action taken by body to remedy, recommendations

Summary

Mrs C had rectal cancer. She underwent radiotherapy and chemotherapy before being admitted to hospital for an operation to remove the tumour. After surgery, Mrs C complained of abdominal pain and became very unwell. A scan showed that she had a leak in her bowel and she underwent an emergency operation. She was admitted to the intensive care unit and then transferred to the high dependency unit. A few days later, she was moved from the high dependency unit to a general surgical ward. The surgeon noted in her medical records that medical input was not sought before this move. She was discharged from hospital several weeks later, after which she received care at home from nurses and had an out-patient appointment.

Mrs C complained about communication with her and her family about the first operation. She said that they were unprepared for the nature and scale of the operation and that staff failed to identify post-operative complication within a reasonable time. She was also concerned about her move from the high dependency unit to a general ward, where staff appeared unable to cope with her serious condition. Finally, she complained about her post-operative care generally, the care she received from a nurse specialist at home following her discharge from hospital and confusion over the follow-up appointment at the hospital.

The board acknowledged that their failure to ensure that Mrs C and her family had a full understanding of the magnitude of the initial surgery and how it was to be carried out had caused considerable distress. This should have taken place at the pre-assessment stage through discussion with the clinical team and provision of written information leaflets. The board said it was also clear that Mrs C and her family had not been properly prepared for the immediate post-operative period. They apologised for these failings and set out an action plan to address them. They also agreed that they had failed in respect of the provision of specialist nursing after Mrs C returned home, and had since initiated a comprehensive and robust action plan.

After taking independent advice from our medical advisers, our investigation found that although Mrs C signed a consent form at an out-patient appointment the day before the operation, the notes on the form did not mention any complications or facts relating to the procedure. We, therefore, found that the board failed to record any discussions about the procedure and its complications or to provide written information before the operation took place. We also found that they failed to provide counselling from a specialist nurse in relation to the surgery, contrary to the relevant guidelines. Although Mrs C was moved from the high dependency unit to a ward that could attend to the monitoring that she needed at the time, this was only ascertained after the event and no medical input was sought before the move. Finally, although we found that the post-operative care was reasonable in all aspects except the lack of involvement of a specialist nurse, this was a significant failing. As the board had already taken significant steps to address most of the failings identified, we only found it necessary to make one recommendation.

Recommendations

We recommended that the board:

- ensure that the patient is formally assessed as being clinically appropriate to move from the high dependency unit in a similar situation.