SPSO decision report

Case: **201303301, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C, a caseworker for an MSP, complained on behalf of a constituent (Mrs B). Mrs B was unhappy with the care and treatment provided to her late father (Mr A) at Hairmyres Hospital in relation to his symptoms (he had intermittent choking problems and a blocked bile duct), his lung cancer, and related nursing care. Tests in 2010 showed abnormalities in Mr A's lungs, but he was not diagnosed with lung cancer until December 2012. Mrs B was concerned about the delay in diagnosing this, and about the investigations and treatment decisions in relation to her father's swallowing difficulties.

We took independent advice from two medical advisers. Our advisers said that Mr A's cancer was diagnosed within a reasonable time, referrals to hospital were dealt with promptly and related treatment decisions were reasonable. The care and treatment of his blocked bile duct was also appropriate. Both advisers said that Mr A's medical history was complex, and that part of the difficulty was that not all his problems were directly linked and many medical specialities were involved. We did not uphold the complaint about his medical care.

We did, however, uphold the complaint about nursing care. Mrs B was concerned about provision of nutrition and fluids, pain relief, and aspects of personal care. She also complained that nursing staff failed to inform Mr A's GP of his death, which the family found distressing. We took independent advice on this from our nursing adviser, who said that although care in respect of many of the aspects that caused Mrs B concern was reasonable, there were failures in monitoring Mr A's fluid and nutrition. Given the significance of these to Mr A's medical problems, we were critical of this. There were also record-keeping shortcomings - nursing staff failed to record what was done to address the family's concerns about one admission to hospital, and did not contact Mr A's GP to let them know about his death.

Finally, Miss C complained that the family's communication needs were not met and that they were left unclear about what was happening. We found, however, that Mr A's medical records contained a number of entries about communication with him and his family. In relation to one aspect (the advice the family received about Mr A's pacemaker) the board accepted that this was incorrect and apologised for the distress this caused. Having considered all the evidence available, however, we were satisfied that the overall standard of communication was reasonable, and we did not uphold this complaint.

Recommendations

We recommended that the board:

- ensure the failures this investigation identified are raised with relevant health care professionals;
- inform us of the actions taken to address the failures in relation to fluid and nutrition monitoring and record-keeping (including informing relevant healthcare professionals of a patient's death); and
- apologise for the failures this investigation identified.