SPSO decision report

Case: **201404412, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained on behalf of her mother (Mrs A) about the care and treatment she received at Monklands Hospital in 2013 and 2014 for liver-related disease. Specifically, she complained that a specialist procedure was not performed in 2013 and the aftercare arrangements were poor; that during a second admission in 2014 Mrs A's condition continued to deteriorate until she was transferred to a different hospital where a liver transplant was performed; and that she was malnourished prior to the transplant.

In their complaint response, the board did not identify failings in the care and treatment but acknowledged that communication with the family could have been better.

We took independent advice from two of our medical advisers, a consultant gastroenterologist (who specialises in the treatment of conditions affecting the liver, intestine and pancreas) and a consultant gastroenterologist and hepatologist (who specialises in liver disease). We found that the treatment given in 2013 was in line with national guidance and, whilst there were records to show that there was an appropriate discharge plan in place, there was no evidence to demonstrate that this had been explained to either Mrs A or her family. Furthermore, given that Mrs A had abnormal blood tests, we were critical that the consultant who discharged her failed to reasonably monitor her. Therefore, we upheld this aspect of the complaint and made three recommendations. We considered that the care given in 2014 was appropriate and, having also taken independent advice from our nursing adviser, we found that there were factors that impacted on Mrs A's ability to take oral nutrition and we did not uphold this aspect.

Recommendations

We recommended that the board:

- apologise to Mrs A for the lack of communication surrounding her discharge plan;
- review their procedures for arranging follow-up clinic appointments and for reviewing abnormal blood results, specific to this case, to identify any learning; and
- share the failings identified with relevant staff.