SPSO decision report

Case: **201508362, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C's late father (Mr A) was admitted to Lawson Memorial Hospital for several months for a period of rehabilitation following a stroke. He was then discharged to a care home but died two days later. The cause of death was established as methicillin-resistant staphylococcus aureus (MRSA), which came as a shock to Mr C and his family as it had not been communicated to them that Mr A had been diagnosed with this. Mr C complained about the lack of communication in this regard and also about a lack of treatment for MRSA.

We took independent medical advice from a hospital consultant who considered that the evidence available to demonstrate the clinical thinking behind Mr A's care was poor. They noted that Mr A's care was complex and that there would have been other factors for medical staff to consider. They said that more consideration should have been given to urine culture results and the potential for persistent infection. Consideration should also have been given to changing his catheter in line with NHS guidelines and the board's own policy on treating infections but there was no evidence that this happened. Neither was there any evidence of Mr A being informed of his diagnosis. The adviser said that this should have been communicated to Mr A and his permission sought to share this information with the family. We upheld this complaint.

Mr C also complained about the appropriateness of Mr A being discharged with MRSA. While Mr C considered that Mr A was still displaying symptoms of urine infection around the time of his discharge, we were advised that an appropriate medical review was carried out and no evidence was found to suggest that the discharge could not go ahead. We noted that the board's MRSA policy confirmed that a diagnosis of MRSA should not prevent discharge of a patient. We did not uphold this complaint.

Recommendations

We recommended that the board:

- feed the findings of this investigation back to relevant staff;
- arrange staff training on catheter related infections and MRSA;
- highlight to microbiology staff the importance of offering additional support to off-site wards in interpreting complex results;
- take steps to ensure future compliance with their MRSA policy, particularly in relation to the communication of a diagnosis to patients and carers;
- take steps to address the identified record-keeping failings and ensure future compliance with General Medical Council guidance in this regard; and
- apologise to Mr C for the failings this investigation has identified.