SPSO decision report

Case: **201803233, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C attended hospital to undergo colonoscopy (a procedure to look at the lining of the large bowel) and gastroscopy (a procedure to look at the inside of the oesophagus and first part of the small intestine). The information booklet she had been given in advance indicated that she would be sedated. However, Mrs C said she was persuaded to go ahead without sedation which she found extremely painful. She said that she felt traumatised and violated. She complained to the board who said that the matter of sedation had been discussed with her and it was her decision to go ahead without it; staff had no recollection of her complaining of pain.

We took independent advice from a gastroenterologist and from a registered nurse. We found that the procedures concerned were ones where sedation would normally be given as the information booklet indicated. There was no evidence that medical staff had discussed the procedures with Mrs C and the associated consent forms had not been properly completed. Similarly, we found concerns about the nursing records and although at one point Mrs C was recorded as having a pain score of 2-3 (out of 4) she was not monitored or assessed further. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Medical staff should fully discuss risks and record the risk and benefits of any medical procedures.
- Nursing staff should follow the Nursing and Midwifery Council (NMC) guidelines when completing records.
- Nursing staff should respond appropriately to pain score data.