SPSO decision report

Case: **201907317, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about various aspects of the care and treatment their late spouse (A) received from the board.

A had a history of vascular (relating to a vessel or vessels, especially those which carry blood) surgery and was admitted to hospital for the removal of a benign tumour. The procedure took place, however, A's condition deteriorated and they were moved to an infectious diseases unit with suspected sepsis (blood infection). A's condition deteriorated further and they were transferred to a vascular and critical care ward in a different hospital on an emergency basis. Later that day, A underwent surgery to remove an infected synthetic artery graft (a piece of living tissue that is transplanted surgically).

A experienced an abdominal bleed and was transferred to a critical care unit. After treatment, A was reviewed by a consultant and returned to the vascular and critical care ward. A experienced a fall on the ward. A later developed a lung infection/sepsis and died.

C complained that the board failed to screen, manage or treat A's infection. C said that A had been discharged from the critical care unit onto the ward too soon. C also complained that the board had failed to properly assess A's fall risk or treat A properly after their fall.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly) and a registered nurse. We found that the screening, management and treatment of A's infection and their discharge from the critical care unit was reasonable. We did not uphold these complaints. However, we found that the board had failed to adequately complete risk assessments, including a falls risk assessment, for A. We upheld this complaint.

We also considered that the board made an error of communication while responding to C's complaint when they referred to MRSA (a bacterial infection that is resistant to a number of widely used antibiotics) instead of MSSA (a bacterial infection which is not resistant to certain antibiotics). We provided feedback to the board about this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for wrongly referring to MRSA rather than MSSA when responding to C's complaint and for their failure to complete A's Falls Risk Assessment; bed rails and 4AT delirium assessments in line with organisational policy. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Falls Risk Assessments and bed rails/4ATdelirium assessments should be carried out in line with the

board’s stated policy.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.