SPSO decision report

Case: **202007160, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received at University Hospital Monklands. A was admitted to hospital to have fluid drained from their abdomen but died in the hospital a few days later. C was concerned that the drain was left in too long and caused A to suffer a perforation of the bowel, and that medical staff delayed and/or failed to investigate whether A had suffered internal damage as a result.

We took independent advice from a consultant hepatologist and gastroenterologist (a physician who specialises in the diagnosis and treatment of disorders of the gastrointestinal tract, liver, pancreas and gall bladder). We found that without a post mortem it was impossible to determine the cause of the perforation. We also found that while A's drain had been left in longer than recommended, it was unlikely that the delayed length of time the drain was left in and the subsequent perforation were related, as A did not have any immediate complications nor signs of problems from the drain for a number of days before developing a bowel perforation.

We found that the clinical action taken by the team involved in A's care at this time was reasonable. Once there was a suspicion of a perforation occurring, a chest x-ray had been carried out and this had been good practice. The board acknowledged and identified lessons to be learned and we considered the board's actions to address what occurred were reasonable. However, we found that the delay in removing the drain was unreasonable and we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable delay in removing A's drain. 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:

- There should be good communication between the medical team (inserting the drain) and the nursing team with regards to the timing and the removal of a patient's drain.

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.