SPSO decision report

Case: **202104338, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C made a complaint about the care and treatment provided to their late spouse (A) by the board. C was concerned that A had sepsis (an infection of the bloodstream) at the time of their discharge. C considered that A would not have died had they remained in hospital.

We took independent advice from a consultant in geriatric medicine (a doctor who specialises in treating older patients) and general medicine. We found that there was a failure to properly assess A's blood and urine test results prior to their discharge. Had this been done, there would have been a greater likelihood that infection could have been diagnosed and treated prior to A's discharge from hospital. Although A may still have died had they remained in hospital, this could have given A a better chance of surviving their illness.

We found that there were failures in communication with A's family. A's family should have been provided with 'safety netting' advice about repeating A's temperature or looking for other potential signs of infection once A had returned home. We also found that there were failings in the board's handling of C's complaint. The board's own complaint investigation did not include all relevant staff for comment, the response was brief and did not provide fully accurate information in relation to A's condition.

In light of the above, we found that the board failed to provide A with reasonable medical care and treatment. We upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to 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/information-leaflets.

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

- Patients whose test results are suggestive of an underlying infection should be fully and appropriately investigated, in line with recognised guidelines. When a patient is discharged, appropriate 'safety netting' advice about worsening condition should be provided.

In relation to complaints handling, we recommended:

- The board's complaints handling system and their investigation should ensure that relevant staff have the opportunity to comment, that complaint responses appropriately address the issues raised and are accurate and that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement.

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.