SPSO decision report

Case: **202204428, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment of their late spouse (A). The day before A's first admission to hospital, the GP submitted an urgent suspicion of cancer (USOC) referral. A was experiencing abdominal pain with vomiting and diarrhoea. The initial diagnosis had been a suspected blocked bowel. After symptoms settled, A was discharged before returning to hospital a few days later with ongoing symptoms. A was discharged home with a plan to return for an outpatient colonoscopy. However, A returned to hospital with a diabetic foot infection resulting in surgery. During this final admission, A was diagnosed with bowel cancer. C considered A was inappropriately discharged from hospital following the first two admissions with no clear diagnosis or plan in place. C said that communication throughout A's hospital admissions was poor and also complained about the nursing care provided to A, particularly in relation to the care given to their feet as a known diabetic.

We took independent advice from a clinical adviser and senior nurse adviser. We found that given A's symptoms, and the USOC referral, the board unreasonably failed to consider A for an inpatient colonoscopy during their second admission to hospital and unreasonably failed to schedule an outpatient colonoscopy for A one to two weeks after discharge. We also found A's second discharge from hospital was inappropriate because their presentation, along with other relevant information, should have alerted clinical staff to the possibility of cancer.

We found that basic nursing care could not be evidenced due to poor documentation and that appropriate assessments were not carried out. We found that the foot care provided to A was unreasonable with no evidence to show wound assessment or monitoring was done to a reasonable standard. We upheld all aspects of the complaint relating to the care and treatment of A.

C also complained that the boards handling of the complaint was poor. We found that steps were taken to agree the complaints issues that would be investigated, regular updates were provided and steps were taken to manage contact with C, Therefore, we did not uphold this aspect of the 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 should receive appropriate nursing care. In particular in relation to Food Fluid and Nutrition, Wound Assessment and Management and Pressure Ulcer Prevention, including CPR for feet.
- Nursing documentation should be completed to the required standard.
- Patients should receive appropriate investigations in relation to their presenting symptoms either during admission or as soon as possible on discharge.

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.