SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **202407574, Lothian NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment
Decision: upheld, recommendations

Summary

C complained about the the care and treatment that their late sibling (A) received following emergency abdominal surgery at the Royal Infirmary of Edinburgh. C said that the board failed to provide them with adequate care and treatment in relation to the placement, monitoring and management of a central venous catheter insertion line (catheter placed into a large vein) and the administration of Total Parenteral Nutrition (TPN, a method of feeding that bypasses the gastrointestinal tract). C also complained that the board failed to adequately communicate regarding a Significant Adverse Event Review (SAER).

The board upheld aspects of C’s complaint relating to communication but did not uphold aspects relating to care and treatment. However, while the SAER did not identify any failings in A’s care, it did identify some improvements to the board’s procedure on the management of central venous catheter insertion lines.

We took independent advice from a consultant anaesthetist. We found that repeated doses of TPN were administered extravascularly (outside of the vein) when A was in an intensive care unit and this was an avoidable complication. We found that there was a failure to communicate adequately with A in providing them with a reasonable explanation as to how and why the complication from the central venous catheter line had occurred. We also found that the SAER failed to acknowledge failings in A’s care and management.

We upheld C’s complaints.

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/meaningful-apologies.

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

- Where appropriate, there should also be effective communication with patients and/or families in relation to complications. Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward.

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.