SPSO decision report

Case: **201303081, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C's late mother (Mrs A) was admitted to the Western General Hospital as an emergency, and had an operation to release pressure in her bowel. She was told that her case would be discussed by a multi-disciplinary team (MDT) in a few days, and that they would advise on her future treatment. Before this could happen, Mrs A fell and broke her hip and was transferred to the Royal Infirmary of Edinburgh for an operation, where two days later she suffered a heart attack and died. Mrs C complained that the board did not keep her fully informed about her mother's condition and what was happening. She said she had understood that her mother's case was to be discussed at the MDT meeting at the Western and this had not happened, which caused both her and her mother upset and confusion. Mrs C was also unhappy because she said that her mother's risk of falling was not properly assessed and prevented by the Western General and that the board took too long to answer her complaints.

We took independent advice from two of our advisers, one a consultant surgeon and the other a nurse. We also considered all the relevant information, including all the complaints correspondence and Mrs A's clinical records, after which we did not uphold three of Mrs C's complaints. Our surgeon adviser said that, after Mrs A's fall, the priority was, correctly, to address her broken hip and make sure that she was recovering from it well before moving on to discuss her future treatment. We noted that although it was not unreasonable that discussions did not take place because of what happened, the board had said that in future the MDT would not cancel discussions without telling the patient and their families why. The records also showed that Mrs A had been assessed as not being at risk from falling, and although she did fall, this could not have been anticipated. Although Mrs C said that the board took too long to address her complaints, we found that they did respond within acceptable time limits. We upheld the complaint about communication, however, as it was clear that the board had not kept Mrs C as well informed as she should have been, particularly about her mother's fall.

Recommendations

We recommended that the board:

- apologise for their failure in this matter; and
- remind staff of the importance of keeping relatives and their families informed, in a timely manner, when an accident/injury occurs.