SPSO decision report

Case: **201401037, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment he received at Hairmyres Hospital after an operation to remove a stoma (a surgically made pouch on the outside of the body) and re-connect his bowel. He also complained that staff (particularly the consultant surgeon) did not communicate well with his wife while Mr C was on a post-surgery ward.

After his operation, Mr C was sick, and his wife raised concerns about his condition. It was initially thought that his bowel had stopped working properly. However, six days after his operation, Mr C's condition deteriorated rapidly. He was taken for a scan, which showed that the join in his bowel was leaking. This led to sepsis (a blood infection). Mr C had an emergency operation to reinstate his stoma and clean his abdominal cavity, and was transferred to intensive care for recovery. He suffered an acute kidney injury as a result of his sepsis.

We took independent advice from our gastrointestinal surgery adviser. The adviser said that the consultant had acted appropriately in terms of the care given to Mr C after his first operation, and that it was reasonable to transfer Mr C to a general post-surgery ward. However, the adviser was critical of the level of communication between the consultant and Mr C and his wife, particularly about the information given to Mr C prior to surgery, and when his condition was deteriorating. We found that the medical notes made no references to discussions between the consultant and Mr C or his wife.

We were satisfied that the care and treatment that Mr C received were reasonable, but the poor standard of communication meant that Mr C and his wife did not fully understand what was happening and why. We were also critical of the consultant's record-keeping, and that the board did not do enough to establish what had happened in their own investigation into the complaint, because they had not sought comments from the consultant, who had been a locum (temporary) consultant.

Recommendations

We recommended that the board:

- remind clinical staff involved in this case of their responsibilities to maintain records of discussions with patients and their relatives;
- take steps to contact the consultant to discuss our findings, in particular in relation to informed consent, communication and record-keeping; and
- apologise to Mr C and his family for their failures in relation to communication, record-keeping and complaints handling, and for the stress and anxiety this caused.