SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201500053, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Miss C complained to us about the care and treatment provided to her partner (Mr A) at Hairmyres Hospital before his death. Mr A had been admitted to hospital because of increasing breathlessness. He was diagnosed with heart failure and subsequently discharged from hospital. However, he was readmitted to hospital two days later. It was initially thought that his heart failure had worsened, but when scans were carried out, it was identified that he had pulmonary fibrosis (a rare condition causing scarring of the lungs).

Miss C complained about the delay in diagnosing that Mr A had pulmonary fibrosis. We took independent advice on this aspect of Miss C's complaint from a medical adviser, who is a consultant in general medicine. We found that the findings from the scans and tests carried out when Mr A was initially admitted to hospital were not in keeping with a diagnosis of heart failure. We considered that Mr A should have remained in hospital and undergone further investigations to determine the cause of his symptoms and we upheld this aspect of Miss C's complaint.

Miss C complained that the board had failed to provide Mr A with appropriate medication when he was discharged from the hospital for a second time. We took independent advice on this complaint from a medical adviser, who is a consultant respiratory physician. We found that home oxygen therapy and other palliative options to alleviate Mr A's symptoms of breathlessness and lethargy should have been considered before he was discharged from hospital. We upheld this aspect of Miss C's complaint. That said, Mr A was suffering with severe pulmonary fibrosis, which was rapidly progressing when he was initially admitted to hospital and this would not have altered his prognosis. We also upheld Miss C's complaints that staff had failed to discuss the seriousness of Mr A's condition with him and his family and that he had been transferred between wards on an excessive number of occasions.

Recommendations

We recommended that the board:

- issue a written apology for the failings identified during our investigation;
- make the medical staff involved in Mr A's care and treatment aware of our decisions on Miss C's complaints; and
- remind the medical staff of the importance of communicating effectively in cases that involve severe life-threatening disease and of the importance of recording this communication in the medical records.