

## SPSO decision report

**Case:** 201504049, Lanarkshire NHS Board  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Outcome:** upheld, recommendations

### Summary

Mr C complained about his late father (Mr A)'s care and treatment in Wishaw General Hospital in the period before his death in June 2015.

Mr A had been diagnosed with terminal cancer in 2014 and in late May 2015 he was taken into hospital to have an oesophageal stent (a mesh tube in his throat) inserted. However, the procedure did not take place and only an endoscopy (a procedure where a tube-like instrument is put into the body to look inside) was performed. In June 2015, Mr A was admitted again and during his admission he suffered a number of falls. Mr C complained that Mr A was not provided with appropriate clinical or nursing care.

We took independent advice from a consultant geriatrician and from a nurse. We found that when Mr A was first admitted in May 2015, there were problems with the documentation available to the surgical team. It was brief and did not show that his condition had been considered in detail. Furthermore, we found that although a number of clinicians had been involved in his case, none of them had been involved with Mr A in any detailed or personal way and communication had been poor. On his second admission, our investigation showed that although it had been detailed in his notes, one-to-one care had not been provided to Mr A. Had it been, a third fall may have been avoided. For these reasons, we upheld Mr C's complaint.

### Recommendations

We recommended that the board:

- make a formal apology for the failures identified;
- ensure that the clinicians involved in the case are aware of the adviser's comments and that they discuss them at their next formal appraisal;
- make a formal apology for the failure to provide one-to-one care observation; and
- review their processes for providing one-to-one care.