SPSO decision report

Case: **201605042, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained on behalf of his late brother (Mr A), who had been a patient at Monklands Hospital. Mr A went missing from the ward but staff failed to notice his absence for a period of several hours. Subsequently, Mr A died outwith the hospital premises a few days later. Mr C complained to the board about the care and treatment they provided to Mr A. His complaints related to observation, medication and shared accommodation on the ward.

In response to Mr C's complaints, the board carried out a significant adverse event review (SAER), which is a type of investigation designed to identify what, how and why a particular adverse event happened. The SAER concluded that ward staff had not observed Mr A properly in terms of their procedures and, therefore, his care fell below a reasonable standard. The review also found that, when Mr A's absence was established, staff did not properly share this information with each other and did not escalate the matter in a timely manner. As a result of the failings identified by the SAER, the board took action to address these issues. Mr C then brought his complaints to us.

We took independent advice from two clinical advisers. We found evidence to support that Mr A's medication was appropriately managed. In addition, his transfer from a single room to shared accommodation was reasonable. Although the board's SAER found that staff had not properly observed Mr A, we were critical that the SAER did not explore the reasons why this failing occurred. We were also concerned that the SAER did not identify evidence of poor recording-keeping by staff in terms of Mr A's medical and risk assessments. We considered that Mr A may have been at higher risk than what had been determined. Due to the poor standard of record-keeping we could not conclude for certain whether Mr A's observation level should have been increased. However, we considered that a greater awareness was required by staff. Whilst we noted that further steps had been taken by the board to address the failings they had identified, we recommended additional action to be taken to ensure these issues do not happen again.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A's family for the poor record-keeping and for the failings identified in relation to observations. The apology should meet the standards set out in the SPSO guidelines on apology, available at www.spso.org.uk/leaflets-and-guidance.

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

- Standardised documents relating to medical and risk assessment should be completed properly.
- The board should ensure that adverse event reviews adequately identify all failures and the underlying causes of untoward events, in line with relevant guidance.
- The findings of this complaint should be fed back to relevant staff in a supportive way.
- Time off the ward should be properly documented and failure to return plans should identify when a patient

fails to return to the ward.

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.