SPSO decision report

Case: **202108871, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received whilst in hospital following a stroke. C said that the board failed to provide appropriate nutrition for A when they lost the ability to swallow. A required a percutaneous endoscopic gastrostomy (PEG) feeding tube to be fitted (a tube passed into the stomach through the abdomen to provide a means of feeding). However, there were delays with this and A died shortly after the procedure was carried out. C was concerned that other types of feeding were not considered by the board and that staff were not appropriately qualified to deliver alternative feeding.

The board said as soon as it became apparent that a PEG feeding tube would be appropriate, a referral was made to have this done. A dietician identified another method of feeding called TPN (a type of nutritional fluid administered to a patient intravenously) however, ward staff were concerned that they were not trained on how to deliver this method of feeding. As such, a decision was taken to expedite the referral to have the PEG tube fitted instead.

Before surgery could take place, A had to be tested for COVID-19. The results of the test were not back in time for surgery to be carried out on the day it was initially scheduled. The board apologised for the delay that this caused.

We took independent clinical advice from a consultant geriatrician (specialist in medicine of the elderly). We found that the clinical decisions made in the management of A's nutrition were reasonable. TPN feeding is not typically used in cases like this one. The standard of care was in keeping with guidance and was of reasonable quality. However, the delay in receiving the results of the COVID-19 test, and the failure to expedite this, was unreasonable. This led to the delay in treatment. On balance, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the delay in receiving the results of the COVID-19 test that led to a delay in A having a PEG tube fitted. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Obtaining the results of tests required before surgery should not be delayed. In cases where surgery is urgent, tests should be expedited where required to ensure that they are received timeously in order to avoid delays in the patient receiving surgery. When delays are experienced, the reasons for this should be noted in the medical records.

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.