SPSO decision report

Case: **202210701, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C's parent (A) was admitted to the hospital's A&E three days after a fall. A had a complex medical history including chronic pain. On admission, A reported lower right-sided chest pain, associated with gradually increasing shortness of breath. A chest X-ray showed no evidence of r ib fractures but a subsequent CT scan showed multiple right-sided rib fractures (from ribs 3-10), a flail segment (when three or more consecutive ribs are fractured in two or more places, causing a segment of the rib cage to become detached from the rest of the chest wall), an intercostal haematoma (solid pooling of blood between the ribs) and a right sided pleural effusion/haemothorax (build-up of fluid/blood between the ribs). A was treated in the Intensive Care Unit (ICU) for one week before being stepped down to the Medical High Dependency Unit (MHDU). A was reviewed by the ICU team as and when required and after becoming acutely unwell they were transferred to ICU again, where they died a few days later.

In relation to A's admissions to MHDU, C complained about problems with A's medication, concerns around pain management and the nursing care A received, in particular issues around fluid and nutrition, and not responding to alarms or adhering to observational guidelines. C also complained that staff in the MHDU failed to provide appropriate care and treatment in response to A's deterioration.

We took independent advice from a consultant in critical care and a senior critical care nurse. We noted that management of A's condition was complex given their history of chronic pain together with a severe acute injury. We found a number of failings in A's pain management, including doses of sustained release oxycodone being administered outwith the appropriate dose interval, an increase in dose of oxycodone which was not clearly justified, and lack of involvement of the acute pain service for ongoing support after A returned to the MDHU from ICU. Taking all of this into account, we found that the board failed to provide a reasonable standard of pain management and upheld this aspect of C's complaint.

We found that NEWS (National Early Warning Score, a tool for identifying deterioration of patients in acute settings) observations were irregular and that there was evidence that nursing staff failed to escalate appropriately when NEWS scores were 5 and above. Nursing records were lacking in detail and there was no evidence of A receiving oral care. On balance, we upheld C's complaint about the standard of nursing care.

We found that overall the response to A's deterioration was reasonable. A was regularly reviewed by consultants, with escalation as appropriate. We did not uphold this aspect of C's complaint. However, we were critical of the board's complaint handling, noting long delays in compiling the complaint response and a failure to keep C updated, and that the board's own investigation did not identify failings picked up by our own investigation.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified as a result of our investigation. 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:

- Observations are undertaken in accordance with the board's observations policy and National NEWS Scoring and Guidance, with appropriate escalation. Nursing staff have an understanding of Person Centred Care Plans. Documentation is sufficiently detailed.
- Opioids are administered strictly in accordance with relevant dose periods. Decisions to increase medication doses are clinically justified.
- The board should review how patients with severe chest trauma are managed by the acute pain service after regional analgesia has been removed, and the patient has been stepped down from critical care. Their consideration should include triggers for referral and consideration of policies to ensure that access to the acute pain service for this group of patients is not determined by the choice of step-down environment or nominated parent team, but rather by the extent of the patient's injuries and likely complexity of their ongoing analgesia management.

In relation to complaints handling, we recommended:

- Complaint responses should consider and respond fully to the issues raised in accordance with The Model Complaints Handling Procedure. They should take into account any relevant national or local guidance in both the investigation and response, and identify and action learning. Complainants should also be kept updated on their complaints in line with the Model Complaints Handling Procedure. Additionally, learning from complaints should be shared throughout the organisation so that actions and improvements can be implemented to prevent the same issues happening again.

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.