SPSO decision report

Case: **202300707, Lanarkshire NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: some upheld, recommendations

Summary

C complained on behalf of a relative (B), about the care and treatment provided by the board to B's late spouse (A).

When A first felt unwell, they visited their GP on three occasions where they were prescribed antibiotics and told they had a chest infection. Following an x-ray, A was prescribed medication to increase the amount of urine produced, with a plan to carry out a follow up x-ray. A visited the GP again with breathlessness and was referred to the hospital where they were admitted and diagnosed with COVID-19. Blood tests showed that A had an infection and a chest x-ray reported fluid on the right side of A's chest. A was initially treated for infection with COVID-19 and a suspected bacterial infection. A was discharged from hospital with a plan to repeat the x-ray as an outpatient. A few days later, A was readmitted and diagnosed with lung cancer and was showing signs of spinal cancer.

A was further told that there was a cancerous tumour pressing on their lungs. A's breathing worsened, they had severe weight loss and they were not eating. Only one family member at a time was permitted to visit A. Staff said that more of A's family would be able to visit if their condition deteriorated. A remained in hospital until their death a week later.

In considering C's complaint, we took independent advice from a consultant in general and respiratory medicine and a senior nurse. We found that the decision to discharge A from hospital was reasonable and did not uphold this aspect of C's complaint. However, we found that it was unreasonable that A's pleural effusion (fluid build up) was not treated on or shortly after admission. Therefore we upheld the complaint that the board unreasonably failed to carry out further investigations whilst A was on the ward.

We also found that A was unreasonably left sitting and sleeping in a chair during their admission, that A's family were not given any additional time to visit when A was at end of life and that there was a failure by the board to notify A's family that their condition was rapidly deteriorating. We upheld these aspects of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified in respect of these complaints. 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:

- Further investigations should be carried out in line with the expected standards for management of pleural effusions in the context of acute admissions.

- In such circumstances, staff should contact the family promptly to inform them of a patient’s deterioration.
- Relevant staff should be aware of changes to guidance.
- The person-centred care plan should be fully completed for each patient and updated with a changing deteriorating picture. When a patient is nursed in a chair it should be clearly documented that this is an informed choice to ensure person centred decision making and regular skin checks completed. Recliner chairs should be obtained promptly where required.

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.