SPSO decision report

Case: **201602247, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his father (Mr A) at Victoria Hospital. Mr A was admitted to A&E after suffering a transient ischaemic attack (TIA, a mini stroke caused by a temporary disruption in the blood supply to part of the brain). Mr A underwent a brain scan. The doctor discussed Mr A's case with a stroke consultant and Mr A was discharged with planned follow-up in the TIA clinic.

Following discharge, Mr C had a stroke and was re-admitted to hospital later the same day.

Mr C complained that staff had failed to take into account that Mr A's wife had recently died and that he would be returning to an empty home on discharge. The board acknowledged that aspects of the communication during the admission were poor, but maintained that the decision to discharge Mr A was appropriate and in accordance with the protocol.

The board apologised to Mr C for the communication failings and outlined steps for improvement. In particular, the board said that they would discuss the issues with staff involved and that a newsletter would be introduced to A&E to share learning. We made a recommendation in relation to this.

We took independent advice from an adviser in emergency medicine. The adviser considered that the doctor's assessment of Mr A was of a good standard and overall they were satisfied that Mr A was appropriately managed in accordance with the board's TIA protocol. The adviser noted that the doctor who assessed Mr A received input from a stroke consultant before discharge and they were satisfied that the decision to discharge Mr A was reasonable. In view of this, we did not uphold Mr C's complaint.

Recommendations

We recommended that the board:

- provide an update on the production of the newsletter.