SPSO decision report

Case: **201608259, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A) at University Hospital Ayr. Mrs C felt that Mr A was kept in the emergency department for too long before being admitted to the hospital, and that he was not appropriately assessed during this time.

We took advice from a consultant in emergency medicine and a stroke consultant. We found that, overall, the care provided to Mr A by the emergency department staff was reasonable but that they failed to complete transfer observations and handover documentation. We found that the initial assessment of Mr A by the stroke team was poor. We acknowledged that the diagnosis of a stroke, such as the one Mr A suffered, can be difficult to diagnose, however, we found that there was a failure to scan Mr A in the appropriate manner and reasoning for decisions made were not documented clearly. Therefore, we upheld this aspect of Mrs C's complaint.

Mrs C also complained that there was a lack of communication to keep her advised of Mr A's diagnosis and treatment. We found that, overall, the medical records showed a reasonable level of communication with Mrs C and, therefore, we did not uphold this aspect of her complaint.

Finally, Mrs C complained that the board's handling of her complaint was unreasonable. We found that, throughout the complaints process, there had been a number of failings including delays and a lack of communication. Therefore, we upheld this aspect of Mrs C's complaint. However, since these events occurred, a new complaints handling policy had been implemented by the board and we therefore made no further recommendations on this point.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide Mr A with appropriate clinical treatment; and for failing to handle Mrs C's complaint in a reasonable manner. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Transfer observations and handover documentation should be completed appropriately by the emergency department to ensure patients are safe to be transferred and appropriate information is passed on to the receiving ward area.
- Assessments made by members of the stroke team, and reasoning for any decisions made, should be documented clearly.

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.