SPSO decision report

Case: **201707902, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment that her late husband (Mr A) received in A&E at the Royal Infirmary of Edinburgh. Mr A was taken to hospital after becoming unwell with chest pains and was treated for a suspected heart attack. Tests carried out showed that Mr A was not having a heart attack and he was referred for a CT scan (a scan that creates detailed images of the inside of the body) to investigate other causes. Before the scan took place, Mr A collapsed and staff were not able to resuscitate him. The cause of death was a thoracic aortic dissection (a condition where the lining of the main blood vessel from the heart is injured). Mrs C felt that a CT scan should have been ordered sooner.

We took independent advice from a consultant in emergency medicine. We found that it was appropriate to investigate and treat Mr A for a heart attack as this is what his symptoms suggested. When a heart attack was ruled out, we noted that a CT scan was ordered within a few minutes and that there was no unreasonable delay in relation to the wait for the scanner to become available. We did, however, identify an unreasonable failing in the observations of Mr A's vital signs as there was a gap in the records of over four hours. On balance, we upheld the complaint and made recommendations in this connection.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the gap in recording vital signs. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Vital signs should be recorded at appropriate intervals for patients in the emergency department.