SPSO decision report

Case: **201803128, Lothian NHS Board - Acute Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, an advocate, complained on behalf of their client (A) about the care and treatment A received at St John's Hospital when they attended after becoming unwell with vomiting. A had also been suffering from migraines over the previous few days. C complained that there was inaccurate reporting of the CT angiogram (a specialised scan using x-rays to look at the heart) which resulted in a delay in diagnosing a stroke; there was a delay in performing a lumbar puncture; and there had been a lack of consistent communication with the family. C also complained that A was not treated fairly due to comments made by staff about their previous medical history and that they did not receive assistance with personal care.

The board accepted that there was a failing in relation to the provisional report of the CT scan and this would have initiated treatment for A's stroke at that time. The board apologised and said that they would highlight the case at their local learning meeting. The board accepted that there was no documented evidence to support that A was receiving help with personal care, for which they apologised. However, they noted that there were regular attempts to keep A and their family updated on care.

We took independent advice from a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans), from a consultant in general medicine and from a registered nurse. We found that, while many aspects of the medical care provided were reasonable (including the timing of the lumbar puncture), there was an unreasonable error regarding the provisional CT scan. This meant that there was a delay between the scan being performed and it being correctly reported. We upheld this aspect of the complaint.

We considered that A would have received medication, such as aspirin, to thin their blood earlier, but the effect of this is to prevent future strokes rather than improve the one that has currently occurred. While this would have added to the distress of A's family, we were of the opinion that the impact on A's clinical outcome would not likely have been significant.

We found evidence of reasonable communication and did not consider that inappropriate comments were made about A's previous medical history. However, we were unable to establish that A received a reasonable level of assistance with personal care because the nursing documentation fell below the record-keeping standards set out in the Nursing and Midwifery Code. Therefore, we upheld this aspect of the complaint.

Recommendations

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

- Patients should receive personal nursing care where appropriate; and this should be clearly and accurately recorded in accordance with the Nursing and Midwifery Code.
- The board should minimise the contribution of any system deficiencies to radiological errors.

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.