SPSO decision report

Case: **201901362, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, a member of the Scottish Parliament, complained on behalf of one of their constituents (A) about the care and treatment they received from the board.

Initial investigations carried out diagnosed A with atrial fibrillation (AF, a problem of the heart characterised by irregular and often faster heartbeat). While waiting for a cardiology (the branch of medicine that deals with diseases and abnormalities of the heart) appointment, A suffered a heart attack and was admitted to Hairmyres Hospital.

C raised concerns that the hospital's cardiology department knew A had a problem with their heart two weeks before they suffered the heart attack and that aspects of A's care and treatment during their admission were unreasonable. In particular, they complained that A was placed in a bed next to a disruptive patient who was suicidal while in the Acute Assessment Unit (AAU), that there was a delay in carrying out a coronary angiogram procedure (a type of x-ray used to examine blood vessels), and that communication by hospital staff was poor. C also complained that A's follow-up rehabilitation treatment after discharge was unreasonable.

We took independent advice from a cardiology adviser. We found that while there were issues identified initially with A's heart, there were no concerning features associated with their AF that would raise suspicion that A might have a heart attack.

While we acknowledged that being in a bed next to a disruptive patient in AAU, must have been very distressing for A at a particularly difficult and anxious time, we found that this reflected the status of AAU as a communal assessment ward and was consistent with standard practice.

Regarding C's concerns about the delay in the carrying out of the coronary angiogram, we found that it was reasonable for staff to delay this procedure in the context of staff being required for other urgent and emergency procedures.

We acknowledged C's concerns about staff communication and how this made A feel, in particular, surrounding the delayed angiogram procedure. While A had expected some face-to-face contact with their consultant, and although this did not occur, we did not find sufficient evidence to show that there was a failure in communication. However, we provided feedback to the board about this.

In terms of the care provided following A's discharge, we found this was of a reasonable standard.

We found that the overall care and treatment provided to A was reasonable. As such, we did not uphold this complaint.

C also complained that the board did not respond reasonably to A's complaint. We upheld this complaint on the

basis that the board did not address all aspects of A’s complaint in their response.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for failing to address all aspects of A's complaint in their response letter. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

- Complaint responses should address the issues raised by the complainant, in line with the Model Complaints Handling Procedure.

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.