SPSO decision report

Case: **201908937, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (B) in relation to care and treatment provided by the board to B's parent (A). C complained that the board had delayed in performing a CT scan when A presented at Belford Hospital with symptoms associated with a stroke. When a CT scan was performed four days after A's admission, it confirmed that A had suffered a stroke.

C also complained that the board again delayed investigating symptoms suggesting that A had suffered a further stroke when A was re-admitted to Belford Hospital the following month. A CT scan performed three days after A's re-admission showed that A had suffered a new stroke or a worsening of the previous one. C also said that the specialist stroke team based at another hospital had not been contacted for clinical input in A's case.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly). We found that, in relation to A's first admission, A was not examined with sufficient care and that the clinicians involved did not act upon symptoms commonly associated with a stroke. As a result, performance of a CT scan had been unreasonably delayed. In relation to A's second admission, we found that A's new symptoms were also inadequately investigated, which led to an unreasonable delay before a further CT scan was performed. We also noted that A's clinical records indicated A's case would be discussed with the specialist stroke team at another hospital but this did not appear to have taken place. We upheld C's complaint but were unable to conclude if A's outcome had been made worse as a result of the shortcomings in the care provided.

When reviewing the complaint, we also found that the board's investigation into C's complaint was unreasonably delayed and that C was not provided with sufficient information about the reasons for the delay or a revised timescale as to when the investigation would be completed.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the delay in performing CT scans following A's admissions to hospital, the failure to fully consider the possible causes of A's stroke and the failure to seek input in A's care from the specialist stroke team. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The relevant clinicians should reflect on the standard of care and treatment provided to A and give consideration as to where improvements could be made in their practice to ensure that (i) symptoms of stroke are adequately investigated as soon as possible; (ii) once a diagnosis of stroke is made, consideration is given to the possible causes of the stroke in accordance with SIGN and NICE guidelines; and (iii) input from stroke specialists is obtained in clinically appropriate cases.

In relation to complaints handling, we recommended:

- Where a response to a complaint cannot be provided within an agreed timescale, the complainant should be provided with adequate information to let them know the reasons why the timescale cannot be met. In such circumstances, complainants should also be provided with an updated timescale as to when they can expect to receive a response. Where an investigating officer is unable to complete an investigation due to absence through long-term sickness, the complaint should be reallocated to a suitable alternative investigating officer to complete the investigation.

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.