SPSO decision report

Case: **201909851, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained that the board failed to provide their late spouse (A) with reasonable care and treatment during three attendances at A&E and an admission to hospital.

The board said that A complained of pain in their right forearm causing them sleep disturbance. However, there was no indication that imaging scans were required as an emergency. A was already under the care of orthopaedics (specialists in the treatment of diseases and injuries of the musculoskeletal system) which was appropriate for the muscle injury A had. Therefore, the assessments, plan, and discharge of A at the first two attendances in the emergency department were appropriate on the basis of what was known at the time. During the third attendance at the emergency department, the board said that investigations indicated that A had a raised marker for infection and inflammation which could have been an indication of underlying condition or malignancy. At this point it was identified that an MRI scan should be carried out, but there was no indication that this was required as an emergency. A was admitted to hospital for further investigations.

We took independent advice from a consultant in emergency medicine. We found that appropriate and timely emergency care was provided to A on each of their attendances at A&E. We also noted that a clinical significant event review was carried out. The issues were fully explored and the board had appropriately reviewed and reflected on learning. We considered that A received reasonable care and treatment at A&E and as an inpatient. Therefore, we did not uphold this part of C's complaint.

C also complained about the board's handling of their complaint. C said that the board did not contact them during their complaint investigation. They also highlighted that the board did not address all their concerns. We found that the board failed to address and respond to a significant part of the complaint raised by C until prompted to do so by this office. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to handle their complaint reasonably. 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:

- The board's complaints handling system and their investigation should ensure that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement. Complaints should be properly assessed in line with the Model Complaints Handling Procedure and all points of complaint should be identified and agreed before the complaint investigation begins.

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.