SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **202103125, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

A's spouse (B) was admitted to hospital for a knee replacement. The operation went well but during B's recovery their condition began to deteriorate and B was transferred to the High Dependency Unit. B went into cardiac arrest, CPR was administered but it was unsuccessful and B died.

C raised complaints on A's behalf about B's treatment during their admission. The board undertook a Local Adverse Event Review (LAER), identified issues with B's care and treatment and made recommendations to address these issues. The board also responded to the complaints raised by C regarding B's treatment. In their response the board reiterated the conclusions of the LAER, their recommendations made in relation to some aspects of B's treatment, and concluded that other aspects complained of by C had been reasonable.

In relation to specific questions about B's admission that C had shared, the board indicated that responses to most of these had been provided at a meeting that had taken place between B's family and a consultant orthopaedic surgeon (branch of surgery concerned with conditions involving the musculoskeletal system) or in the LAER report. The board provided a response to one other question in the response to C.

We took independent advice from a specialist in orthopaedic surgery. We found that observations of B should have been increased, their care escalated and that antibiotics should also have been commenced sooner. We upheld this aspect of the complaint.

In relation to the provision of answers to questions raised in the complaints submitted, we found that clear responses from a clinician were available to the board's complaints team within a month of the questions having been raised. The board provided answers to some of the questions at a meeting the following month but clear answers to the remaining questions were not provided until SPSO became involved and specifically asked for them almost two years later. Given this, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for an unreasonable delay in an urgent assessment being undertaken, a failure to escalate B to the medical team and the decision to administer antibiotics not being made sooner. The apology should meet the standards set out in the SPSO guidelines on apology available at www. spso. org. uk/information-leaflets.
- Apologise to A that clear answers to the questions raised were not provided within a reasonable timeframe. 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:

- Patients should receive timely medical review and if appropriate antibiotic therapy commenced without delay.

In relation to complaints handling, we recommended:

- Complaints are properly responded to in line with the Board’s 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.