SPSO decision report

Case: **202107585, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the board failed to provide them with reasonable care and treatment when they were admitted to an acute medical unit, specifically that they were discharged too soon and that there was a delay in diagnosing that they had suffered a stroke.

We took independent advice from an adviser that specialises in acute medicine. We found that the board incorrectly documented that a CT scan had been carried out. Given the seriousness of C’s symptoms and their outcome, it was of concern that this incorrect information was documented in C’s medical records. We found that C should have remained in hospital to be assessed in more detail before they were discharged. We found that more consideration should have been given to C’s symptoms and the possibility that they were related to a stroke. In particular, a CT scan should have been carried out earlier, which could have led to an earlier diagnosis and treatment with medication. On C’s readmission, C’s stroke was visible on a CT scan. It therefore was possible that a CT scan, on their first admission, could have shown C’s stroke.

In relation to C’s nursing care, we found that we would have expected to have seen more detailed nursing notes about C before their discharge, for instance, in relation to C’s walking ability. The board apologised for the miscommunication which occurred between nursing staff in relation to C’s fitness for discharge and said that learning had been put in place for effective communication. The board said that this was communicated verbally and therefore there was no paper evidence. We considered this to be unsatisfactory and we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www. spso. org. uk/information-leaflets .

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

- Where a patient presents with neurological symptoms after a colonoscopy, consideration should be given to the possibility that they may be related to a stroke, that their suitability for discharge should be appropriately assessed and their condition appropriately reviewed to see if their symptoms settle and for relevant scans to be carried out prior to discharge. The rationale for a patient’s discharge should be properly documented with details of all relevant assessments fully documented. Information recorded in a patient’s records should be accurate.

In relation to complaints handling, we recommended:

- Complaint investigations should be carried out in line with the NHS Model Complaints Handling

Procedure. The board should comply with their complaint handling guidance to ensure that a full and proper investigation is carried out. Where learning is identified, there should be clear evidence of the action subsequently taken.

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.