SPSO decision report

Case: **202110696, Scottish Ambulance Service**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to A by the Scottish Ambulance Service (SAS). A had a pacemaker fitted and developed a severe headache and rash. A phoned NHS 24 as they were finding it difficult to breathe. Paramedics attended A at home but A was not admitted to hospital. A phoned NHS 24 again the following day and when paramedics attended, they sought telephone advice from a consultant at the local hospital. The consultant advised that A should take paracetamol and see the GP the following morning. A phoned the GP the next day and was told to go to the COVID-19 hub where A collapsed and was taken to hospital by ambulance. A was admitted to hospital and died the following day from sepsis (blood infection). C complained about the decision not to take A to hospital and is concerned that the paramedics failed to recognise the signs of sepsis and to take the appropriate action.

We took independent advice from a registered paramedic. We found that in hindsight it was unreasonable that SAS did not recognise the seriousness of A's condition, including applying any weighting to past medical history, in particular recent surgery and the fact that the presence of infection could have been the result of sepsis. However, we found that many of the clinical signs and symptoms observed in A would have been present in a patient experiencing COVID-19. Based on the conditions and guidelines SAS were operating to at the time we found that it was reasonable that the paramedics' working diagnosis was COVID-19.

Whilst we considered it was reasonable that A was not taken to hospital, we were critical that there is no evidence that A was informed of the risks and benefits of the option of staying at home, going to hospital or of any alternative options available. We also found that it was unreasonable that key information was not passed to the consultant during a call and that record keeping was unreasonable. Furthermore, we found that it was unreasonable that during the paramedics second attendance, the further set of observations taken 20 minutes later unreasonably failed to include A's temperature. Finally, in relation to the first attendance, we considered it was unreasonable to conclude that A was improving, particularly without carrying out a further set of observations. Overall, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified. 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 be appropriately advised of the risks and benefits of the available options, for example the option of staying at home, going to hospital or of any alternative options available. This information should be documented to confirm the advice given, and details of discussions held regarding treatment options.
- Full and complete information should be obtained during observations of a patient so that advice is

appropriately provided and recorded on the basis of that information. Where appropriate, consideration should be given to carrying out a further set of observations prior to reaching a view on a patient's condition.

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.