SPSO decision report

Case: **202300524, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

C complained about the care and treatment that the board provided to their parent (A). The complaint relates to several different primary and secondary care services, including A's medical practice, which was managed directly by the board. A had a long history of peripheral arterial disease (a condition where a build-up of fatty deposits in the arteries restricts blood supply to leg muscles).

A experienced gradually worsening pain in both their legs and had contacts with the Out of Hours (OOH) service, their GP and the board's vascular team. Ultimately, A was admitted to hospital due to worsening critical limb ischaemia (severely blocked flow to one or multiple hands, legs or feet). It was decided to amputate A's leg but, following the surgery, A's condition deteriorated. They were diagnosed with myocardial infraction (a heart attack) and died in hospital.

C complained about several aspects of A's care and treatment which covers both the period up to, and the time during, A's admission to hospital. Firstly, they complained that the OOH Advanced Nurse Practitioner (ANP) failed to provide reasonable care and treatment. The board's position was that the care and treatment provided by the ANP was reasonable but they apologised that C and A had been given the expectation that an OOH GP would attend.

We took advice from an independent GP adviser. We found that the care and treatment provided was reasonable, and that the ANP had appropriately reviewed A's medical history before attending. Therefore, we did not uphold this complaint.

C's second complaint related to A's medical practice. C stated that a GP in the practice had unreasonably failed to diagnose A's condition correctly and provide appropriate treatment. The board concluded there were missed opportunities to see A face to face. However, they considered the practice's clinical decision-making to be reasonable.

We took advice from an independent GP adviser. We found that different GPs may have taken different courses of action based on the same set of circumstances. However, this did not mean that the course of action taken here was unreasonable. Overall, we found that the care and treatment the practice provided to A was reasonable. Therefore, we did not uphold this complaint.

C's third complaint related to the outpatient vascular care and treatment that the board provided to A prior to their admission to hospital. In C's view, the Vascular Consultant involved in A's care unreasonably refused to admit A to hospital in conjunction with A's GP. The board concluded that A's care and treatment plan under the care of the vascular team was managed appropriately. While they regretted not admitting A earlier, this would have been unlikely to change the outcome.

We took independent advice from a vascular consultant. We found that the vascular input provided by the board

prior to A’s admission to hospital was reasonable. We also found that given A’s circumstances, the decision not to insist that admission to hospital was urgent represented established good practice. Therefore, we did not uphold this complaint.

C’s fourth complaint related to the clinical treatment provided to A following their admission to hospital. We took independent vascular advice on this complaint. We found that the clinical decision-making of the vascular team was reasonable. This included the decision to proceed with amputation in the absence of any alternative treatment options. In respect of A’s myocardial infraction, we found that the care and treatment from a vascular perspective was reasonable. We also concluded that there was a record of appropriate discussions regarding DNACPR and the risks of amputation. Given this, we did not uphold this complaint.

C’s fifth complaint related to the nursing care provided to A during their admission to hospital. The board had acknowledged some failings in this respect, particularly around communication. We did not uphold this complaint.

C’s final complaint related to the end of life care provided to A. We took independent nursing advice. We found that the end of life care, as documented in the records, was reasonable. We did not doubt C’s account of how traumatic A’s death was. However, in the absence of additional evidence that indicated staff failed to carry out the kind of actions that they should have, we did not conclude that the care provided was unreasonable. Given this, we did not uphold this complaint.