SPSO decision report

Case: **202301846, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the treatment provided to their late parent (A) when they attended hospital with shortness of breath and abdominal distension (swelling). Following assessment, A was prescribed a blood-thinning medication and was discharged with a plan to return for a scan within 48 hours to look for blood clots in the lungs. A deteriorated within hours of returning home. They were taken to hospital by ambulance and admitted for treatment. Their condition deteriorated significantly. Investigations revealed worsening heart failure and they died within a few days. The board initially considered sepsis to be A's cause of death but a post mortem later established this as congestive heart failure.

We took independent advice from a consultant cardiologist (specialists in diseases and abnormalities of the heart). We found that it was reasonable for A to have been prescribed blood thinners and referred for a CT scan when they first attended hospital. However, on the basis that A's clinical observations were abnormal, in particular their blood gas results, we found that A should have been admitted as they required oxygen. Therefore, we upheld this part of C's complaint.

C complained that the board failed to provide appropriate care and treatment in response to A's deterioration. We were critical of the board for gaps in A's records, meaning we were unable to establish what nursing checks were carried out on the day A deteriorated. However, we found that medical staff acted appropriately in response to A's deterioration. A's deterioration was a result of heart failure, leading to multi-organ failure. A's family felt that there was a lack of clarity regarding A's condition and what they were being treated for. The board recognised that there had been communication failings, apologised and confirmed that learning had taken place. We found that the plans for investigation and treatment were appropriate. It was reasonable for clinicians to suspect sepsis when A's condition deteriorated, and to commence treatment with broad spectrum antibiotics. There was no evidence that the outcome in this case could have been avoided. We did not uphold this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and C's family for not admitting A when they attended hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C and C's family for the poor complaints handling in this case. 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:

- Clinical staff are confident about when to admit patients with respiratory failure who do not have a specific diagnosis.

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.