SPSO decision report

Case: **202302913, Lothian NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained that the board failed to provide their parent (A) with reasonable care and treatment when they attended the A&E with symptoms including a loss of sight in one eye. C raised concerns about the delay in assessing A and failures by staff to reasonably diagnose and treat A. C also said that the board failed to reasonably communicate and provide A and C with sufficient information after A was taken to a cubicle, to provide A with appropriate personal care, to adequately record information about A's care and treatment and to follow the relevant policies and procedures in providing care and treatment to A.

We took independent advice from a consultant neurologist and a nurse. We found that there was an unreasonable delay in A being assessed by a doctor. We also found that there was poor record keeping in A's medical and nursing records, which showed the level of care and observation A had received was unreasonable. We found that, had A's observations been recorded as required, it was possible that a deterioration in A's condition would have been picked up sooner. Consequently, we found that the care and treatment provided to A in the A&E was unreasonable. We, therefore, upheld this part of C's complaint.

C also complained that, after A was transferred to the high dependency unit, a consultant neurologist failed to sensitively explain to them about A's diagnosis and prognosis. We found that adequate and appropriate information was conveyed to C by the consultant neurologist and the communication between them had been clinically appropriate and satisfactory. It was not possible to determine whether or not the consultant neurologist had failed to explain this sensitively. We did not, therefore, uphold this part of C's complaint.

C further complained that a senior research nurse failed to take reasonable steps to contact them regarding a stroke research study. We found that there was a failure to take reasonable steps to contact C regarding the stroke research study. We, therefore, upheld this part of C's 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 www.spso.org.uk/information-leaflets.

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

- A significant adverse event review should be carried out.
- Basic observations should be carried out to the frequency required for the presenting condition of the patient to allow any deterioration in the patient to be identified timely and acted on as soon as possible. Records should be accurate and reflect the care and interventions carried out to the standard required by the Nursing and Midwifery Council.
- Where a patient safety incident occurs, a datix should be completed. There should also be evidence of

reflection and learning for the staff involved in relation to such incidents.

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.