SPSO decision report

Case: **202402634, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, no recommendations

Summary

C complained about the care and treatment provided to their parent (A). A was admitted to hospital with a suspected stroke, confusion and poor mobility. A CT scan was performed but the results were not reviewed until a few days later. The result was discussed with other specialists and a further scan was requested. A's warfarin treatment (blood thinning) was reversed because A's condition had deteriorated. C was concerned that A's condition was not properly recognised as a stroke and that imaging of A's head was not reviewed. Consequently A's blood thinning medication was not stopped promptly.

The board carried out a Significant Adverse Event Review (SAER) which identified delays in reviewing A's scan, and a lack of clarity between medical staff over who was responsible for organising tests for A, as well as poor communication. C felt the SAER lacked rigour and failed to address all the issues in A's care.

We took independent advice from a consultant geriatrician (specialist in medicine of the elderly). We found that the SAER lacked detail and did not contain sufficiently clear recommendations to ensure the failures in A's care did not reoccur. It also did not adequately address the decision making around A's scan or the level of awareness amongst clinicians of the scan being performed.

During our investigation the board provided further evidence of the feedback provided to staff, and the actions taken in response to the incident involving A. We found that these were reasonable and proportionate. The board accepted that the SAER had not adequately explored all the issues in the case. Therefore, we upheld C's complaint but did not make any further recommendations.