SPSO decision report

Case: **202500322, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) during their admission to hospital. A was admitted with symptoms suggestive of a stroke and significantly elevated blood pressure. Initial CT imaging and angiography (a type of x-ray used to check blood vessels) were inconclusive, and possible diagnoses included stroke, hypertensive encephalopathy (brain dysfunction caused by severely elevated blood pressure), or a post-ictal state (following a seizure). An MRI scan was planned but aborted for safety reasons. A's condition later deteriorated, and a repeat CT scan showed stroke in the back of the brain. A died a day after admission.

We took independent advice from a consultant stroke physician. We found that there were aspects of A's care which were reasonable, including prompt assessment, appropriate imaging, decisions made regarding treatment of blood clots, and MRI scanning and safety. We found that it was also reasonable to consider and treat hypertensive encephalopathy. However, we found that record-keeping fell below the expected standard. In particular, there was a failure to keep contemporaneous records on the day that A was admitted as there was no repeat National Institutes of Health Stroke Scale score noted after the initial CT scan. There was also inconsistent recording of staff grades, which reduced clarity regarding levels of clinical oversight. This added to uncertainty about the diagnosis, but it did not affect A's outcome. We upheld this part of C's complaint.

C complained about the board's communication with A and their family during the admission. We found that that the board reasonably explained the working diagnosis, management plan and diagnostic uncertainty. Where miscommunication occurred, the board acknowledged this and apologised. Overall, we found that communication was reasonable and did not uphold this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this report. 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:

- Medical records should be comprehensive and completed in line with professional standards.

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.