

SPSO decision report



Case: 202501264, Grampian NHS Board
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their spouse (A) received from the board during admissions to Dr Gray's Hospital (Hospital A) and Aberdeen Royal Infirmary (Hospital B).

A was admitted following episodes of vomiting blood and received treatment for gastric varices (enlarged blood vessels in the stomach lining). C complained that the board did not investigate or treat A's condition timeously, and that treatment was only given when their condition deteriorated. C complained that an oesophageal perforation occurred as a complication of a procedure to stop bleeding. C also complained about aspects of nursing care at Hospital B.

We took independent advice from two advisers, a consultant hepatologist, who provided advice on the medical care and treatment, and a senior nurse, who provided advice on the nursing care and treatment.

In relation to Hospital A, we found that there were aspects of A's care which had been reasonably managed. Specifically, a recognised tool was used to assess the severity of the upper gastrointestinal bleeding which had occurred. However, there were aspects of A's care which we considered unreasonably managed. In particular, having identified A as being at high risk of bleeding, there were delays in acting on this result, arranging diagnostic endoscopy, and making a timely referral and transfer to Hospital B for ongoing treatment. On balance, we upheld C's complaint about Hospital A.

In relation to Hospital B, we found that it was reasonable to seek specialist advice about the treatment of A's condition from another health board. While a complication had occurred when inserting a tube to control bleeding, we found that the management of this was reasonable. We also found that Hospital B had reasonably acknowledged the nursing care incidents which had occurred and taken appropriate steps to learn and improve from them. However, there were aspects of A's care and treatment which were unreasonably managed by Hospital B. In particular, having identified A as being at high risk of further bleeding, there was an unreasonable delay in providing definitive endoscopic treatment. On balance, we upheld C's complaint about Hospital B.

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.spsso.org.uk/meaningful-apologies.

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

- Patients presenting with confirmed variceal bleeds should be offered treatment appropriate to their presentation, assessed risk, and ongoing symptoms. When a complication occurs following placement of a Sengstaken-Blakemore tube, the action taken should be appropriate and without risk of harm to the

patient.

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.