SPSO decision report

Case: **201101084, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment that his mother (Mrs A) received from a hospital after she was admitted with a severe headache. Mrs A was diagnosed after about 13 hours with a subarachnoid haemorrhage (a type of stroke where there is a bleed from one of the blood vessels running over the brain). Mr C was concerned about the length of time it took for the hospital to carry out a scan and felt that the brain damage his mother suffered could have been less severe had the scan been done sooner. Mr C also complained about the time it took for the board to respond to his complaint and that the response did not answer all of his concerns.

The board accepted there had been an unacceptable delay of approximately four hours between the time it was decided the scan should be done until it was actually carried out. They were unable to provide a clear reason for the delay but outlined that there were communication problems between the junior doctor and the radiology department. As a result of their findings, the board said that they would rewrite their protocol in relation to scanning and out-of-hours care.

We found further communication problems that impacted on identifying the need for an urgent scan. The medical records show that the on-call medical consultant said that Mrs A was to be scanned immediately in the event of further deterioration. However, when her condition further deteriorated early that morning, before the scan was done, neither the on-call doctor nor the radiologist was informed.

We were unable to say whether earlier diagnosis would have influenced the final outcome in Mrs A's case. However, it would have at least provided the possibility of early transfer and intervention, along with reducing the overnight anxiety the family suffered. Overall, therefore, we considered the care to be below the standard that could reasonably be expected.

We also identified significant delays in the board's responses to Mr C's letters of complaint, which were not in line with the guidance issued by the Scottish Parliament at the time. Whilst we noted inconsistencies in the board's first response to Mr C, their second response was more accurate and in keeping with the information contained within Mrs A's medical records.

Recommendations

We recommended that the board:

- apologise to Mr C and Mrs A for the failings identified in our investigation;
- review the new protocol to ensure that there is appropriate involvement of the senior medical staff responsible for the care of the patient when reviewing patient care, and that appropriate clinical features are included in the protocol to aid diagnosis;
- review clinical communication at the time of handover between all clinical staff, including radiology, to ensure urgent scan requests are effectively communicated and expedited; and
- apologise to Mr C for the delay in responding to his complaint and for providing contradictory information.