SPSO decision report

Case: **201103320, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, action taken by body to remedy, recommendations

Summary

Mrs A had been treated by her GP for some time for a disease of the lungs, chronic obstructive pulmonary disease (COPD). After having problems with breathlessness for two months, she was admitted to hospital. The admitting doctor thought that Mrs A's symptoms were not typical of COPD and suspected that the cause of her distress was a pulmonary embolism (a weakness in the wall of a blood vessel in the heart or chest that can cause a sudden rupture). However, after examination, investigations and observations, another doctor noted COPD as the 'preferred diagnosis', with pulmonary embolism as a differential (or possible secondary) diagnosis.

Mrs A was discharged from hospital after two days, but collapsed and died nine days later. A post-mortem confirmed that pulmonary embolism was the cause of death. After Mrs A died, the board carried out a critical incident review (CIR) (an assessment of why the incident occurred), which found that there had been failings in her care and recommended action to remedy this.

Mrs A's daughter (Mrs C) complained to the board about her mother's death and about the action taken in response to it. She remained dissatisfied with their responses and complained to us. As the board fully accepted responsibility for Mrs A's death, our investigation focussed only on the remedial action they had taken to address the concerns raised by the CIR. We referred the CIR report to our medical adviser to assess the remedial actions taken.

Our adviser said that the CIR had been of high quality and the timelines proposed were appropriate. He felt, however, that although the board had taken positive action, some of the recommendations were still aspirational. We, therefore, asked for further evidence of the remedial action taken or on-going. From the response, we were satisfied that further progress had been made, but considered that there were still some areas requiring further action and/or monitoring. Although, therefore, we did not uphold the complaint, we asked the board to continue to work towards the aspirations in the action plan and to report back to Mrs C and to us. We also made a recommendation relating to how they use information from the DATIX system (an electronic management system for recording incidents).

Recommendations

We recommended that the board:

- incorporate specific elements into rural practitioners training programmes to address any issues identified from DATIX incidents;
- continue to work towards establishing an integrated networking system within the organisation; and
- set up a formal, structured clinical audit programme agreed with the clinical director.