SPSO decision report

Case: **201101922, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: upheld, action taken by body to remedy, no recommendations

Summary

Mrs C's husband (Mr C) was admitted to the emergency department of a hospital suffering from severe, sudden headaches and vomiting. He was seen by a doctor about four hours later. He lay in the bed for a further few hours before being taken for an x-ray and admitted to the acute medical unit. The following day, Mrs C called the acute medical unit and was told that her husband had pneumonia, which was incorrect. A scan, also undertaken that day, showed that Mr C had a sub-arachnoid haemorrhage. As soon as the results of the scan were known, he was taken to the neurosurgical unit where further tests were carried out.

Mrs C complained on behalf of Mr C about the delay in providing appropriate care and treatment to Mr C following his admission and that the acute medical unit gave her incorrect information about Mr C's condition when she contacted them.

The board had already acknowledged, in responding to Mrs C's complaint, that there was an unacceptable delay in providing Mr C with appropriate care and treatment and that incorrect information had been given to Mrs C about her husband's condition. The board's local protocol on the management of sudden onset headache also made clear that it was important that scans were undertaken as soon as possible when a sub-arachnoid haemorrhage is suspected.

The board had already taken action following Mrs C's complaint. In particular, they had apologised unreservedly for the delay Mr C experienced and that Mrs C had been given incorrect information when she called. The board also provided their action plan following Mrs C's complaint, which included a summary of learning and improvements. The learning points identified included both a specific and general reminder to staff to organise investigations promptly

and the importance of giving accurate and correct information to relatives about a patient's condition. The complaint had also been discussed with the doctor concerned. We commended the board for the action they had already taken following Mrs C's complaint and had no recommendations to make.