SPSO decision report

Case: **201204944, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

After Mr C's daughter (Mrs A) experienced several episodes of breathlessness, she was seen by her GP, who concluded she had a virus. Over the following days, Mrs A remained breathless. She collapsed at home and her GP was called out. He found that her blood pressure was low, but rising. He concluded that she had had a vasovagal episode (a temporary loss of blood to the brain) but was improving. Mrs A had further collapses over the following days and was eventually taken by ambulance to hospital. Shortly after arriving there, Mrs A collapsed again and, despite attempts to revive her, she died. Mrs A was found to have had a pulmonary embolism (a blockage in the artery that transports blood to the lungs). Mr C complained that there was a lack of urgency from accident and emergency (A&E) staff in diagnosing the cause of his daughter's symptoms. He also complained that Mrs A was left alone in a cubicle and that he and his wife were not allowed to sit with her.

After taking independent advice on this complaint from one of our medical advisers, we upheld Mr C's complaints. We found that Mrs A was seen by a nurse immediately on arrival at the hospital. However, she asked to use the toilet and was allowed to do so, which delayed triage (the process of deciding which patients should be treated first based on how sick or seriously injured they are) by around 30 minutes. Mrs A was triaged by a nurse and was prioritised as 'urgent', meaning she would be seen by a doctor within one hour. Our adviser said that Mrs A's symptoms were sufficiently abnormal to merit being prioritised as 'very urgent', which should have resulted in a doctor seeing her within ten minutes. Mrs A collapsed around twenty minutes after triage. We were satisfied that Mrs A was treated appropriately following her collapse, but we criticised the board for failing to identify the seriousness of her condition. Although we found it appropriate for Mrs A to be given privacy to use the toilet, we were also critical that Mrs A's parents were not allowed to sit with her in the cubicle, or that staff did not ask Mrs A whether she wished to be visited.

Recommendations

We recommended that the board:

- apologise to Mrs A's family for the issues highlighted in our investigation;
- share this decision with staff carrying out triage in A&E with a view to ensuring an appropriate combination of tool-based prioritisation and professional judgement;
- take steps to ensure that the Fife Early Warning system (a system based on observation, and used to monitor changes in the patient's condition) is being properly implemented and understood by staff in A&E;
- take steps to ensure that the triage process and decisions reached regarding treatment priority are properly documented; and
- remind nursing staff of the Nursing and Midwifery Council guidance on standard of conduct, performance and ethics 2008.