SPSO decision report

Case: **201300802, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis; communication
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that the Royal Infirmary of Edinburgh provided to her late mother (Mrs A) who passed away 12 days after being admitted there after having had a stroke. Mrs C was also concerned about poor staff communication about Mrs A's deteriorating condition, and the way in which the board dealt with her complaint.

After taking independent advice on Mrs C's complaints from one of our medical advisers, we did not uphold her complaint about her mother's care and treatment. The adviser said that although Mrs A's condition was complex, the care and treatment she received was in line with national guidance recommended by the Scottish Intercollegiate Guidelines Network on the management of stroke patients. We found evidence that accident and emergency (A&E) staff assessed Mrs A and arranged a brain scan in a timely manner. Furthermore, A&E staff sought prompt advice from specialist staff. Although aspirin could have been given to Mrs A sooner, it was administered within the 48 hour guideline recommended by NHS Quality Improvement Scotland, and the adviser thought it unlikely that Mrs A's outcome would have been any different even had it been given sooner. We also concluded that Mrs A was promptly assessed by both physiotherapy staff and speech and language therapy staff after she was transferred to the stroke ward. In addition, frequent medical reviews were carried out and appropriate monitoring and treatment of her heart rate to help keep it under control.

We did, however, uphold Mrs C's other complaints about communication and complaints handling. When the board met with Mrs C to discuss her complaint, they apologised for the lack of information about Mrs A's deteriorating condition on the day of her admission to A&E and accepted that there were significant communication problems when Mrs A was transferred to the combined assessment unit and then to the stroke ward. They said that they were taking steps to address this.

The board accepted that there were mistakes in their written response to Mrs C's complaint. They apologised for these, issued an amended version of the correspondence, and reimbursed Mrs C for the money she had to pay to receive their letter, which had insufficient postage on it. We also found that, although Mrs C told the board that they had written to her at the wrong address, there was a delay of three months before she received a further letter from them responding to her complaint as they had used the incorrect address again. We also established that: they had not responded within the 20 working day target set out in the Scottish Government's complaints procedure guidance; contrary to that guidance, the board's internal complaints policy permitted them to suspend the 20 working day response target when the person complaining accepted the offer of a meeting, and they had not kept Mrs C updated about when their response would be issued.

Recommendations

We recommended that the board:

- provide evidence to support the action they have taken to improve communication between staff and relatives regarding patients who have suffered a stroke;

- feed back to relevant staff the importance of ensuring timely and accurate responses to complaints, and of providing updates when the 20 working day timescale cannot be met, in accordance with the Scottish Government's complaints guidance; and
- review their internal complaints policy to ensure that it is in line with the Scottish Government's complaints guidance.