SPSO decision report

Case: **201303704, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C was referred by her GP to the Acute Medical Unit of Ninewells Hospital after reporting a ten-day history of increasing chest and upper abdominal pain. She was admitted in the afternoon and blood tests and a measurement of her heart-rate were taken. She was then reviewed by a consultant later in the evening who told Mrs C that her condition was 'not cardiac' (not related to her heart). The blood test results were not available during this review and were not checked until the following morning. Mrs C was placed on a heart monitor overnight but when she needed to use the lavatory, she was taken off the monitor and not reconnected when she returned to bed. Mrs C was reviewed the following morning by a different consultant who told her that the blood test results confirmed she had had a heart attack.

Mrs C complained to us about the care and treatment she received from the board; about entries in her medical records; and about the response to her complaints.

Our investigation, which included taking independent advice from a medical adviser and a nursing adviser, found that while some of her care and treatment was reasonable, there were some failings. In particular, the delay in reviewing the blood test results and in not reconnecting Mrs C to the heart monitor were not considered to be reasonable.

Mrs C was also concerned that there were inaccuracies and/or fabrications in her medical records but we found no evidence of this. There was one entry which related to blood test results for another patient which had been entered into Mrs C's records. The board had acknowledged this and although we upheld this complaint, we made no recommendations in view of remedial action already taken.

Finally, Mrs C was concerned that the responses to her complaints had been unreasonable. While our investigation identified that some improvement could be made, we also found that genuine efforts had been made to address Mrs C's concerns.

Recommendations

We recommended that the board:

- take action to ensure that all medical staff on the Acute Medical Unit are reminded of the importance of following up and/or chasing test results, and undertaking all tests recommended or ordered during a patient assessment;
- take action to ensure that all nursing staff on the Acute Medical Unit are reminded of the importance of patients being kept on, or immediately reattached to, cardiac monitors while under investigation / observation for a suspected cardiac event;
- issue a further written apology for the failings we identified; and
- take action to ensure that all staff involved in complaints handling are made aware of current and relevant guidance on apology.