SPSO decision report

Case: **201405779, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment his late wife (Mrs C) received from St John's Hospital and the Royal Infirmary of Edinburgh. Mrs C attended the emergency department at St John's Hospital where she had tests carried out that suggested that she may be suffering from a viral illness and/or a urinary infection. She was discharged home with antibiotics but remained unwell. She visited her GP four days later who arranged for her to be seen by the medical assessment unit at St John's Hospital. There were delays in Mrs C being seen by a doctor and she was found to have had a small heart attack. Further tests revealed that she had significant coronary artery disease (blockages of the arteries) and so she was transferred to the cardiology team at the Royal Infirmary of Edinburgh. It was further identified that she had an overactive thyroid. Surgery to address the blocked arteries was carried out a few days later. However, within 24 hours Mrs C's condition continued to deteriorate and further investigations were difficult to perform given her poor state of health. Mrs C was transferred to another hospital but died shortly afterwards.

We took independent advice on this case from three medical advisers who are specialists in emergency medicine, endocrinology (hormone-related diseases) and cardiology. On Mrs C's first visit to the emergency department of St John's Hospital, a junior doctor failed to refer her to a more senior doctor before discharging her. We therefore found that the care provided was unreasonable. We were also critical that, on Mrs C's second visit to St John's Hospital, there was a delay in her being admitted and seen by a doctor. The board accepted and apologised for this. We considered that the treatment given thereafter at St John's Hospital was reasonable. We concluded that the care provided by the Royal Infirmary of Edinburgh was appropriate and in accordance with national guidelines. However, we found that communication with Mr and Mrs C about Mrs C's condition was unreasonable by both hospitals.

Recommendations

We recommended that the board:

- ensure the junior doctor reflects on the failings identified at their next appraisal;
- ensure St John's Hospital reviews its policy for patients who should be reviewed by a more senior doctor before discharge from the emergency department, taking account of high-risk presenting symptoms;
- review its pathway for patients referred from their GP to the medical assessment unit at St John's Hospital to ensure that patients who should be seen urgently do not experience an excessive wait;
- share with relevant staff involved in Mrs C's care at the Royal Infirmary of Edinburgh the importance of explaining to patients and their family relevant matters related to their condition, and document that this has been done; and
- apologise to Mr C for the failings identified in relation to Mrs C's initial visit to the emergency department and for the communication failures identified.