SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201507712, Scottish Ambulance Service**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment his late wife (Mrs A) received from the Scottish Ambulance Service. Mrs A collapsed at home and Mr C phoned the ambulance service. Mrs A was taken to hospital and died shortly after arrival. Mr C said the ambulance service did not provide a reasonable standard of care and treatment for his wife and that there was an unreasonable delay in transferring his wife to hospital. He also said the ambulance service did not reasonably investigate and respond to his complaint.

We obtained independent medical advice on the case from a consultant in emergency medicine. The adviser said that after obtaining a first electrocardiogram (ECG) tracing (a test used to check heart rhythm and electrical activity), which was of adequate quality, the crew then spent 21 minutes obtaining a further five ECG tracings, the reason for which was unclear given that the first reading was adequate. The adviser also said the ambulance crew's clinical assessment of Mrs A was unreasonably minimal, especially with regards to regularly measuring her vital signs. For these reasons, we upheld this part of the complaint.

The adviser said that the time spent trying to obtain an ECG and communicate with the intended receiving hospital was unjustifiably prolonged. He said this was especially the case as Mrs A was only a ten minute drive from the hospital that she was eventually taken to, and because she was so critically unwell. The adviser said that when it became clear that obtaining the ECG and transmitting it to the first intended hospital was becoming problematic, the ambulance crew should have urgently taken Mrs A to the second hospital, which was the closer hospital, for medical assistance. From there a decision could have been made about Mrs A's onward transportation to the first intended hospital. We upheld this part of the complaint.

We also considered that the ambulance service did not reasonably investigate and respond to Mr C's complaint and we upheld this part of the complaint. We asked the ambulance service to provide documentary evidence of their remedial action they said that had taken regarding complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failings identified in care, treatment and complaints handling. This apology should meet the standards set out in the SPSO guidance on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- The Scottish Ambulance Service should learn from this case. This learning should be across the organisation, and include governance and clinical staff (especially those involved in this case). Learning should be shared with appropriate support and training provided.
- Notes of patient encounters should be comprehensive, and completed timeously and accurately. The

status of the patient, treatments administered and sequences of events should be clearly recorded. Clinical staff should be trained and competent to record such notes.

- Crews should understand when it is inappropriate to stay on scene with critically ill patients for prolonged periods, particularly when there are difficulties in obtaining ECGs and transmitting them to hospital.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.