SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201508292, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of Mrs B about the care and treatment given to Mrs B's husband (Mr A) after he had two wisdom teeth extracted under general anaesthetic at Raigmore Hospital. Ms C said that on his return home after discharge, Mr A became very unwell. Mrs B twice phoned the hospital for advice but it was only after her second call that he was asked to return. When Mr A returned to the hospital, no record was found of the calls made.

After examination and a scan, Mr A was diagnosed with sepsis and was admitted to intensive care where he stayed for about a week. Ms C said that information about Mr A's discharge failed to reach his GP and dentist in a timely way. Mrs B made a formal complaint to the board about these matters. Ms C complained that they failed to properly address Mrs B's concerns.

The board were of the view that they had treated Mr A reasonably although they recognised a number of shortcomings (namely that records of phone calls to the hospital were not properly recorded and that letters and discharge information were delayed).

We took independent advice from a consultant in oral and maxillofacial surgery and found that there was no record of phone conversations prior to Mr A's admission. However, after his re-admission Mr A's care had been reasonable. We also found that there had been delays in issuing discharge letters and that addresses had been omitted. Furthermore, Mrs B's complaint had not been properly addressed in that although these shortcomings had already been identified by the board, they had put no plan in place to prevent the same thing happening again. We therefore upheld Ms C's complaint.

Recommendations

We recommended that the board:

- advise of the action taken in the interim to prevent the same thing happening again (in relation to information not being recorded in the clinical notes) and if no action has been taken, they should advise of their proposals;
- advise what they have done to address communications concerns since they were brought to their attention and failing any action, they should undertake an audit of the clinics and ward concerned to establish the extent of any continuing problem and provide their solution should problems remain; and
- make a formal apology for their oversights to Mr A and Mrs B.