SPSO decision report

Case: **201508391, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the nursing and medical care received by her brother (Mr A) over two admissions to Belford Hospital. Mr A's first admission was due to severe abdominal pain and vomiting. He was treated and discharged the same evening. Mr A's second admission was two days later after he was found disorientated in his home. He was assessed and a request was made for an out-of-hours (OOH) scan of his brain. This was refused and the scan was not carried out until the following morning. The scan showed bleeding on Mr A's brain and he was transferred to another hospital for surgery. Ms C also complained that the board had failed to respond appropriately to their complaint.

Ms C said Mr A was not properly assessed during his first admission. She said he should not have been discharged after receiving morphine and said Mr A had no memory of when he was discharged or how he got home.

Ms C said Mr A had been left in soiled clothing during his second admission, which had been distressing for his family. She said nursing staff had failed to provide personal care until the family had insisted. Ms C also said the failure to perform a brain scan sooner had put Mr A's life in danger. Ms C said the family had repeatedly told medical staff they believed Mr A was displaying symptoms of a brain injury.

We took independent medical advice from a consultant physician. The adviser said that Mr A's care and treatment during the first admission was adequate. However, the adviser said that Mr A was displaying sufficient symptoms of brain injury to justify OOH scanning earlier than he received the scan. This was unreasonable and should have been addressed in the board's complaint investigation.

We also took independent advice from a nursing adviser. They noted the records showed that staff had attempted to provide personal care to Mr A during his second admission, but that he had not been compliant.

We found the nursing care provided to Mr A was of a reasonable standard. However, we found that the medical care was not, since he should have had a brain scan sooner, although this delay did not impact on the outcome of his treatment. We also found the board's complaint response contained inaccuracies and Ms C's complaint was not investigated to a reasonable standard. We made recommendations to address the failings we identified in these different areas.

Recommendations

We recommended that the board:

- review their local protocol on the management of patients displaying abnormal brain function to ensure it is in accordance with Scottish Intercollegiate Guidance Network (SIGN) guidelines 107 and 108 which relate to the management of headache in adults and patients with strokes;
- draw the attention of the radiologist in this case to the requirement of SIGN guideline 108 for imaging for

patients with suspected stroke;

- ensure the reasons for any delay in a complaint response are fully explained at the appropriate time;
- review this complaint to establish why the final response contained inaccuracies; and
- apologise in writing for the failings identified in this investigation.