SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201604707, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment given to her late husband (Mr A) when he attended the out-of-hours primary care emergency centre at the Victoria Ambulatory Care Hospital. He was discharged home but a few days later was admitted to the emergency department of Queen Elizabeth University Hospital, where he was treated for a severe chest infection with possible underlying heart problems. After some hours Mr A's condition was considered to be near to death and it was indicated that he was suffering from aortic stenosis (a narrowing of the left ventricle of the heart, which can cause problems such as heart failure) and fluid on his lungs. Mr A was later transferred to the medical high dependency unit where he was reviewed and underwent numerous tests. He was then transferred to the intensive care unit, where he later died.

Mrs C complained to the board and when she remained unhappy with their response she brought her complaints to us. Mrs C complained to us that:

the assessment of Mr A at the out-of-hours service was unreasonable

the care and treatment provided to Mr A at Queen Elizabeth University Hospital was unreasonable

the communication with herself, Mr A, and the family during Mr A's admission was poor

the board failed to respond fully to her complaints.

We took independent advice from a nurse practitioner and from consultants in emergency medicine and cardiology. We found that Mr A had been reasonably and appropriately assessed at the out-of-hours service and we did not uphold this aspect of the complaint.

We found that it would have been better if Mr A had been seen and assessed by the cardiologist shortly after his admission to Queen Elizabeth University Hospital, rather than the cardiologist only speaking to the emergency medicine team on the phone, which is what had happened. A face-to-face assessment would have allowed for a better assessment, and for a discussion with Mr A and Mrs C about Mr A's symptoms, treatment and prognosis. We also found that opportunities were missed to keep Mrs C updated on Mr A's condition. As such, we upheld Mrs C's complaints about the care and treatment provided to Mr A, and about the communication with the family.

With regards to the board's complaints handling, we found that the board addressed all of the concerns that were raised with them. We were satisfied that the responses were provided promptly and with appropriate detail. We did not uphold Mrs C's complaint about the board's complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise that a cardiologist did not see Mr A sooner. The apology should meet the standards set out in the SPSO guidelines on an apology available at www.spso.org.uk/leaflets-and-guidance.
- Apologise for missing opportunities to keep Mrs C fully updated on Mr A's condition.

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

- In cases of aortic stenosis, a cardiologist should assess and physically examine the patient as soon as possible.
- Relatives should be updated on their family member's condition and care.

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.