SPSO decision report

Case: **201605213, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her at Perth Royal Infirmary when she had back problems. Mrs C complained that when she attended the A&E department on two occasions, she was not appropriately assessed before being redirected to another service. Mrs C also complained that, when she was admitted to the hospital, she was not provided with appropriate pain relief medication and that there was a delay in her being given surgery. Mrs C further complained that the information passed from A&E to her GP was not appropriately detailed.

We took independent advice from an A&E consultant and from a neurosurgeon. We found that the first time Mrs C had presented to A&E she was appropriately assessed. However, we found that the second time she presented there was a failure to accurately document the assessment undertaken, which meant that it was not possible to say whether it was appropriate to have redirected Mrs C to another service. We upheld this aspect of Mrs C's complaint. We also found that when Mrs C was admitted to hospital, there was an unreasonable delay in providing her with pain relief, particularly as she had been recorded as being in severe pain. We also upheld this part of Mrs C's complaint.

With regards to her surgery we found that, based on Mrs C's symptoms, there was no unreasonable delay in her having surgery. We found that the time between Mrs C being admitted to hospital and undergoing surgery was unlikely to have had any negative impact on her outcome. We also found that the information passed from A&E to Mrs C's GP was reasonable and included all of the necessary information. We did not uphold these two aspects of Mrs C's complaint.

Mrs C had also complained that the board did not answer her question regarding whether her current condition could have been avoided had she received emergency surgery at an earlier point. Whilst we recognised that this was an important matter to Mrs C, we did not consider this question to have been clearly asked of the board when she initially complained. We did not uphold this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to properly document her assessment during her second attendance at A&E. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Appropriate pain relief should be provided to patients, and staff should check with patients whether they require pain relief medication.

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.