SPSO decision report

Case: **201607454, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C's father-in-law (Mr A) attended the Emergency Department (ED) at Victoria Hospital with severe facial injuries following a fall from a bicycle. He was reviewed by a doctor and transferred to oral and maxillofacial surgery (OMFS - surgery which treats diseases and injuries of the mouth, head, neck, face and jaws) for treatment of the cut to his face, then discharged.

Within the following week, Mr A attended two out-patient appointments at Queen Margaret Hospital to check his wound and remove the stitches. While waiting for the second appointment, Mr A collapsed at the hospital. Medical and nursing staff attended, but no record was made. They told Mr A to visit the ED after his out-patient appointment. However, Mr A remained quite unwell and the family returned to the hospital to ask for help. An ambulance was arranged to take Mr A to Victoria Hospital where a scan showed that he had a skull fracture and bleeding inside the skull. Mr A died shortly afterwards.

The board undertook a Rapid Event Investigation which found failings in the clinical care and processes. They said that there was no communication about head injury care when Mr A was transferred from the ED to OMFS. This meant that nursing staff did not carry out neurological observations (observations of the brain and nervous system), and Mr A was not given information about head injuries when he was discharged. Mr A was also given the wrong advice following his collapse in the hospital, as he should have been taken to the minor injuries unit for further assessment and transfer to Victoria Hospital. The board apologised for the failings found. The family felt that the board's response was unreasonable, and Mr C brought the complaint to us.

Mr C complained that the medical care and treatment provided to Mr A throughout his attendances at Victoria Hospital and Queen Margaret Hospital was unreasonable. We took independent advice from consultants in emergency medicine and OMFS. We found that regular neurological observations should have been taken while Mr A remained in hospital (either in the ED or OMFS) and he should have been given information on head injuries on discharge. Whilst we acknowledged that the board had taken appropriate action to address some of the failings, we were concerned that some of the Rapid Event Investigation recommendations were not specific and clearly linked to the failings found, and two recommendations had been marked off as complete without any evidence of action being taken. In light of this, we upheld Mr C's complaints about medical care and treatment.

Mr C also raised concerns that the nursing care provided to Mr A at Victoria Hospital was unreasonable. We took independent advice from a nurse. We did not find any evidence that nursing staff had missed any concerning signs or symptoms, and we found that the nursing care provided to Mr A was reasonable. Therefore, we did not uphold Mr C's complaint about the nursing care provided to Mr A.

Mr C also complained that the board's response to the complaint was unreasonable. We found that, although it could have been more clearly written at points, the board's response was reasonable. We did not uphold this part of Mr C's complaint.

Recommendations

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

- Patients with an injury to the head should receive neurological observations, regardless of where they are cared for.
- Patients with an injury to the head should be given head injury information on discharge from the ward.
- Recommendations arising from a review of a patient's care should clearly identify changes to prevent the situation reoccurring.

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.