SPSO decision report

Case: **201607664, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his mother (Mrs A) during her admission to University Hospital Crosshouse. He raised particular concerns about an initial cancer misdiagnosis for what was a chest infection / pneumonia. We took independent medical advice from a consultant physician who considered that it was reasonable for medical staff to have considered the possibility of a cancer diagnosis given Mrs A's presentation and background. They advised that this did not impact on the treatment provided as reasonable steps were taken to continue to treat for infection, while planning appropriate investigations. However, the adviser said it appeared that communication with the family may have been unduly weighted towards the likelihood of cancer. In addition, they noted that there was a delay in the clinical team receiving an x-ray report, which might have contributed to the lack of clarity and prolonged the apparent overestimation of the probability of an underlying cancer. On balance, we did not uphold this aspect of the complaint but we made some recommendations.

Mr C complained that the focus on a cancer diagnosis led to a delay in commencing appropriate treatment. He noted that Mrs A's blood pressure rose unchecked resulting in her suffering a stroke. While the adviser reiterated that treatment for infection was appropriately continued, they identified that the treatment choice for the initial 24 hours was unreasonable. They noted that Mrs A's CURB 65 score (a score which guides treatment for community acquired pneumonia) should have been calculated and this would have indicated the need for a second antibiotic. After the initial 24 hours, however, the adviser noted that a stronger antibiotic was appropriately administered. The adviser noted that there were factors preventing optimal monitoring and treatment of Mrs A's blood pressure, but they considered the management of this was reasonable in the circumstances. They noted that there were other potential factors which might have contributed to Mrs A's stroke and could not solely attribute this to her blood pressure. On balance, we did not uphold this aspect of the complaint but we made a recommendation for action by the board in relation to the initial choice of antibiotic.

Mr C also raised concerns about the board's handling of his complaint. We were critical of the board in this regard. We did not consider there to be sufficient evidence to demonstrate that the issues raised were thoroughly investigated. In particular, no written report of the investigation was produced. A meeting was held and this was followed by a short letter detailing some action points. This was issued outwith the required 20 working day period and no explanation for the delay was given. Mr C then had to chase on several occasions for updates on actions taken and, even then, the board did not sufficiently demonstrate learning from the complaint. There was also an oversight by the board in terms of timely further contact with Mr C, for which they had already apologised. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to the family for the failings in relation to communication, medical treatment, and complaints handling. 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:

- Medical staff should be guided by the CURB 65 score when treating for community acquired pneumonia.
- Medical staff should communicate clearly with patients and relatives to ensure they understand any diagnostic uncertainty, and the purpose and aims of the treatment options being explored.
- Clinicians should know how to easily ask for a radiology opinion and, where a formal x-ray report is required, this should be returned to the clinical team within a reasonable timeframe.

In relation to complaints handling, we recommended:

- The board should review their handling of this case with a view to making improvements and ensuring compliance with their statutory responsibilities regarding complaints handling, as set out in the Can I help you? Guidance.

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.