SPSO decision report

Case: **201701675, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A) at Ninewells Hospital. Mr A was resident in a care home and had Alzheimer's disease. He was referred to the emergency department by his GP as he was suffering from hip pain and could not bear weight. The GP asked that staff at the hospital rule out bony injury as a cause of Mr A's symptoms. X-rays were carried out and Mr A was discharged back to the care home after staff found no significant changes from previous x-rays. Four days later, an emergency referral was made for Mr A and he was admitted to hospital. Subsequent tests showed that Mr A had an abscess (a painful swelling caused by a build-up of pus) in his hip. It was determined that he was not suitable for surgery and Mr A was referred to the palliative (end of life) care team. Mr A died in hospital a few days later. Mrs C complained that Mr A's care in the emergency department was unreasonable and that there had been confusion over his palliative care referral. She also complained about how the board handled her complaint.

We took independent advice from an acute care consultant and from an emergency medicine consultant. The advice highlighted that Mr A's pain and inability to straighten his leg should have prompted further action by the staff who saw him in the emergency department. However, there was no indication that earlier treatment would have changed the outcome for Mr A. We also found that national guidance from the Scottish Intercollegiate Guidelines Network (SIGN) in SIGN 111 recommended tests that could have identified Mr A's infection earlier and that the care he received fell short of what he required as a patient with dementia. Therefore, we found that the care and treatment Mr A received was unreasonable and upheld this aspect of Mrs C's complaint.

In relation to communication around palliative care arrangements, we found that the board had identified failings and had apologised to Mrs C. Therefore, we upheld this aspect of Mrs C's complaint but made no recommendations as we considered that this had been adequately dealt with by the board.

Finally, we found that Mrs C had not been kept properly updated during the complaints process, which exceeded the 20 working day timescale set out in the board's complaints handling procedure. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the decision to discharge Mr A without further investigation of the cause of his hip pain and for the failings in the handling of her complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at:https://www.spso.org.uk/leaflets-and-guidance.

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

- Emergency department staff should take appropriate account of patients' cognitive impairments given that these make them more vulnerable to healthcare associated harm.

- SIGN 111 should be followed for patients with suspected hip fracture.

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.