# SPSO decision report

SPSO Scottish Public Services Ombudsman

**Case:** **201704019, Fife NHS Board**
**Sector:** health
**Subject:** admission / discharge / transfer procedures
**Decision:** not upheld, recommendations

## Summary

Ms C complained to us about the care and treatment her later father (Mr A) received from the cardiology department at Victoria Hospital. Mr A had been referred to the hospital by his GP because he was feeling some discomfort in his chest after exertion and increasing fatigue. When he attended the hospital, Mr A had a scan. This showed significant impairment of the pumping function in his heart.

A letter from the hospital to Mr A's GP also referred to a significant recent increase in the frequency of his chest pain and a corresponding reduction in the amount of effort required to bring on these pains, along with recent chest pain at night. These are characteristic features of unstable angina (a coronary condition which can be predictive of an impending heart attack.) The hospital changed Mr A's medication and made an appointment for him to see a consultant cardiologist the following week. However, Mr A continued to have chest pain and died six days later.

Ms C complained that the cardiology department should have admitted Mr A to hospital given the findings at the initial appointment. We took independent advice from a consultant cardiologist. We found that it had been reasonable not to admit Mr A to hospital and we did not uphold the complaint. However, we found that the cardiology department should have given Mr A and his GP more information about his condition and its management. We made recommendations to the board in relation to this.

Ms C also complained that a doctor discussed the decision not to resuscitate Mr A whilst he was in a very critical condition. We recognised that this would have been distressing for the family, but given the seriousness of Mr A's condition, it had been reasonable to discuss the issue of resuscitation. We did not uphold this aspect of Ms C's complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to provide Mr A with adequate information about his diagnosis and guidance as to what to do if he deteriorated whilst awaiting review. 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:

- Patients given a diagnosis of unstable angina or severe but stable angina should be clearly informed of the diagnosis and should have clear guidance about what to do if their condition deteriorates whilst awaiting review. This information should also be shared with their GP.

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.