SPSO decision report

Case: **201705340, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment her late husband (Mr A) received at Galloway Community Hospital after he attended the emergency department (ED) with chest pain. Mr A was diagnosed with gastritis (inflammation of the stomach lining) and was discharged home. He died shortly after from a pulmonary embolism (PE, a blood clot in the blood vessel that carries blood from the heart to the lungs). Mrs C was concerned that Mr A was discharged from the ED without a troponin test (a type of blood test to help confirm or exclude damage to the heart) being carried out. Mrs C also questioned why the ED doctor had not suspected a blood clot when they were aware that Mr A had been treated previously for prostate cancer.

The board carried out a critical incident review of Mr A's care and treatment. They found that a repeat electrocardiogram (ECG, a test that records the electrical activity of the heart) should have been performed given abnormalities had been identified and that a troponin test should have been done. In addition, there was no record of family history/other relevant factors. The board said that they would share these findings with the staff involved in order to ensure learning and undertook to source readily available out-of-hours troponin testing at Galloway Community Hospital.

We took independent advice from a consultant in emergency medicine. We did not consider that Mr A's symptoms were indicative of a PE, however, we determined that it was unreasonable to discharge him with a diagnosis of gastritis. We found that Mr A should have been admitted to hospital and that a repeat ECG and troponin test should have been undertaken. We, therefore, upheld Mrs C's complaint. However, we considered that it was unlikely Mr A's outcome would have been different because ECG and troponin testing is not a test for PE.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to admit Mr A to hospital, arrange a repeat ECG scan, and obtain a blood troponin measurement. 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:

- Staff should ensure in similar circumstances that patients are admitted to hospital.

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.