SPSO decision report

Case: **201705783, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained that his shoulder dislocations went undiagnosed for around eight months after he attended the emergency department on a number of occasions at Crosshouse Hospital and during an in-patient stay. After Mr C's shoulder dislocations were identified at an orthopaedic (the branch of medicine specialising in the treatment of diseases and injuries of the musculoskeletal system) clinic appointment, he underwent shoulder replacement surgery. Mr C also complained that he was not informed about heart problems he experienced whilst he was an in-patient and that the board failed to handle his complaint appropriately.

We took independent advice from a consultant in emergency medicine and a consultant in acute medicine. We found that the board had acknowledged that Mr C's injury should have been picked up during his admission and had apologised to him. The board also took steps to share Mr C's case with medical staff for learning and improvement. However, we found that there was no evidence to demonstrate that Mr C's shoulders had been examined on one occasion when he had attended the emergency department.

In terms of Mr C's concerns that he was not informed about the heart problem he suffered during his admission, we found that there was no records to show that this had been explained to him and understood given he had memory loss.

In relation to the board's handling of Mr C's complaint, we found that the board took ten months to respond. We acknowledged that Mr C's case was complex, however, we considered that this delay was unreasonable. We also found that the board took four months to arrange a meeting to discuss his complaint and that the written response lacked detailed explanation. We upheld all of Mr C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failure to examine his shoulders and failure to discuss with him and document the heart problems he had during his admission. 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:

- Patients attending the emergency department should receive a full assessment of their presenting symptoms.
- Staff should ensure that a patient's care is fully explained and that such discussions are clearly recorded in the clinical records.

In relation to complaints handling, we recommended:

- Complaint meetings should be arranged in a timely manner; and written responses should provide sufficient explanation and address all the points raised in line with the NHS Complaints Handling Procedure.