SPSO decision report

Case: **201707594, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late brother (Mr A) by the board. Mrs C was concerned that failings in Mr A's care and treatment led to his death. The cause of Mr A's death was pulmonary embolism (a blood clot in the lungs).

Mrs C complained that the board did not give Mr A an appropriate consultation or examination when he attended the out-of-hours service and was seen by a doctor and a nurse. We took independent advice from a GP adviser and from a nurse. We found that the board held no records of Mr A's consultation with the doctor or the nurse, and we considered this to be unreasonable. In response to our investigation, the board acknowledged that they did not hold adequate records. They said that a reminder had been issued to out-of-hours staff about good record-keeping standards, and that audits of reports had since been carried out. We asked to see evidence of this. We upheld this aspect of Mrs C's complaint.

Following Mr A's attendance at the out-of-hours service, he attended A&E at Monklands Hospital. Mrs C complained that appropriate investigations were not carried out. We took independent advice from a consultant in emergency medicine. We found that the majority of the investigations carried out in A&E were reasonable. We also found that the history and examinations undertaken would not reasonably have led doctors to suspect a pulmonary embolism. However, we found that there was a failure to investigate an abnormality on Mr A's electrocardiogram (ECG - a test which records the electrical activity of the heart). This abnormality would indicate the possibility of an acute coronary sydrome (when the heart is not getting enough blood), which should have been excluded through further investigations. We noted that, even if these further investigations had been carried out, it is not possible to conclude that Mr A's pulmonary embolism would have been identified. We upheld this aspect of Mrs C's complaint.

We also found that the board's own complaints investigation did not identify or address the failings in care provided to Mr A, and so we made a recommendation in relation to this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and her family for the failure to record the consultation with the doctor and the assessment carried out by the nurse at the out-of-hours service and the failure to investigate the abnormality on Mr A's ECG in A&E. 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:

- Abnormalities on patient ECG's carried out in A&E should be properly investigated.

In relation to complaints handling, we recommended:

- The board's complaints handling system should ensure that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement.