SPSO decision report

Case: **201800996, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment her late sister (Ms A) received in Dr Gray's Hospital before her death. Ms A attended the emergency department in the hospital after striking her head. She had suffered a laceration (cut in the skin), which was glued shut, and she was then discharged. On the following day, she was admitted to the hospital with a high heart rate and shortness of breath. It was subsequently noted that Ms A was suffering from acute chronic kidney injury and chronic atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). She became unresponsive and was taken for a CT scan to check if her head injury was contributing to her loss of consciousness. Ms A died in the radiology department.

We took independent advice from an emergency medicine adviser and a consultant in acute medicine. We found that the standard of documentation for Ms A's presentation to the emergency department was poor. It was also unreasonable that she was not scanned in the emergency department before she was discharged, given her reduced level of consciousness and confusion; her headache; and the fact that she was on anticoagulant medication (medication to prevent blood clots). Further tests should have been carried out and her discharge from the emergency department was contrary to guidance. In addition, the advice given to her when she was discharged from the emergency department would have been challenging for Ms A to understand and retain. It was also surprising that, when she was admitted to hospital, Ms A was given increasing doses of beta-blockers given that she had an allergy to. Therefore, we upheld this aspect of the complaint. The board said that they have taken action to address these failings and we have asked them to provide evidence of this.

Ms C also complained that the board had failed to provide an accurate account of Ms A's death. We found that the board's response on this matter had been accurate. We did not uphold this aspect of the complaint.

Ms C complained that the board failed to communicate appropriately with her family. We found that it had been unreasonable for the board not to contact the next of kin when Ms A deteriorated. We upheld this aspect of the complaint. However, we noted that the board had acknowledged and apologised for this failure and we made no further recommendations in relation to this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the failure to provide reasonable care and treatment to Ms A in the hospital's emergency department. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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.