SPSO decision report

Case: **201801229, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment her late mother (Mrs A) received at Aberdeen Royal Infirmary. Mrs A had a history of a number of health issues and was admitted to the cardiology unit (the branch of medicine that deals with diseases and abnormalities of the heart) with a diagnosis of atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and congestive heart failure. While she was in hospital, Mrs A had a heart attack but Ms C said that she was not told about this. She also said that Mrs A was not properly monitored nor given dialysis to reduce the fluid she retained. Mrs A's condition deteriorated and she later died.

We took independent advice from a consultant cardiologist. We found that Mrs A's symptoms should have alerted staff to the possibility of internal bleeding and that neither the additional diagnosis of unstable angina (chest pain caused by reduced blood flow to the heart muscles) nor a management plan were documented. Therefore, Mrs A's emergency management plan could have been affected, however, it is unlikely to have changed her immediate outcome. There was also no evidence that Mrs A's deteriorating condition had been communicated to her family. Therefore, we upheld Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to consider internal bleeding, to document the additional diagnosis of unstable angina and its management, and no evidence of deterioration being communicated to the family. 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:

- All potentially important admission diagnoses should be clearly documented and updated in the light of investigation results and clinical review. A clear management plan should be written for each admission diagnosis especially where it may involve a change in medication or withholding of therapy, an invasive procedure or potential risk to a patient as in the case of acute coronary syndrome. Treatment options and discussions should be recorded.
- Changes in a patient's condition such as a deterioration as in this case should be appropriately communicated to relatives. Serial investigation results should be reviewed (and documented) against previous ones and against admission results.