SPSO decision report

Case: **201801984, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment her daughter (Miss A) received from the board's out-of-hours GP service on two separate occasions, and from Aberdeen Royal Infirmary during two separate admissions. Mrs C believed that the out-of-hours service had not properly assessed Miss A and should have admitted her to hospital. Miss A underwent an appendectomy (appendix removal surgery) during the first hospital admission and then required to have a further operation for a pelvic abscess which is a recognised complication of appendicitis. Miss A was also found to have Crohn's disease (an inflammatory bowel condition) which further complicated matters. Mrs C believed that it took a long time for staff to decide what to do when Miss A was readmitted to Aberdeen Royal Infirmary, that an unusual antibiotic was administered, and that the medical staff tried too many times to insert cannulas.

We took independent advice from a GP and a consultant in general and colorectal (bowel) surgery. We found that the care in relation to the out-of-hours service was of a reasonable standard, because there were clear records made by both GPs of a detailed history being taken, appropriate examination performed, observations taken and tests carried out, with advice given on what to do if Miss A's condition worsened. We also took into account that appendicitis is not always a straightforward diagnosis to make and that other conditions, such as kidney infection, can mimic this. We did not uphold this aspect of the complaint.

In relation to the first hospital admission, we found that whilst the timing of antibiotic treatment and surgery were slightly outside national guidelines, we did not consider these delays to be unreasonable. Nevertheless, although it was reasonable to discharge Miss A on antibiotic treatment and arrange for blood tests some days later, we were critical that this safety-netting measure was not appropriate. We considered that arrangements should have been made for follow-up review within 48 to 72 hours, given Miss A's c-reactive protein (a marker of inflammation) had risen again and that she had a fever. Therefore, we upheld this aspect of the complaint.

In relation to the second hospital admission, we found that the choice of antibiotic treatment was reasonable. In addition, we considered that the problems with cannulation, whilst distressing for Miss A, was not because of sub-standard care, and that the time taken to perform another operation was reasonable given the fact that re-operating is a major undertaking; and there had been an outbreak of flu at Aberdeen Royal Infirmary, which resulted in Miss A being transferred to another hospital. Therefore, we did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and Miss A for failing to put in place an appropriate safety netting measure at the time of the first discharge from hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Surgical staff should arrange appropriate follow-up review post-discharge where relevant to ensure robust safety measures are in place.

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.