SPSO decision report

Case: **201808030, Orkney NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their late relative (A) received. A became unwell whilst abroad and was treated in hospital, at which time their blood thinning medication was stopped. Upon A's return home, they sought advice from their medical practice and arrangements were subsequently made for A to be admitted to hospital. After a period of six days, A was discharged from hospital. Their blood thinning medication was not restarted pending investigations. A then suffered two strokes and later died.

C complained about a number of issues related to: communication; failure to manage blood thinning medication; no head scan being performed prior to A's first stroke; the time taken to perform scans; matters related to an echocardiogram (a scan used to look at the heart and nearby blood vessels); management of the first stroke; and that a post mortem was not performed. C also complained that the board failed to respond to additional complaint correspondence they had sent.

The board's investigation identified areas of care that were of an unacceptable standard and they made a number of recommendations to address the failings.

During our investigation, we took independent advice from a consultant geriatrician (a specialist in medicine of the elderly). We did not identify evidence of unreasonable practice in the board's care in relation to a head scan not being performed prior to A's first stroke, nor did we identify any failings related to the management of A's first stroke. Nevertheless, we found that there were unreasonable failings related to communication; management of A's blood thinning medication; the echocardiogram and the post mortem. We, therefore, upheld this complaint.

We also investigated C's concerns about the board's handling of their complaint. We found that there were issues raised in C's additional letter that were not fully addressed by the board. We considered that a clear written response should have been provided to C. We concluded that it was unreasonable that the board did not provide a written response to the points laid out in C's additional correspondence. We, therefore, upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and the family for the unreasonable failings in A's care and treatment and for the inaccurate reference in the Significant Adverse Event Review report that it was the GP's recommendation that A did not go on holiday. 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:

- Appropriate consideration should be given to the restarting of blood thinning medication following clinical procedures, such as biopsy.

- Comments made by families during the Significant Adverse Event Review process should be reasonably responded to.

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.