SPSO decision report

Case: **202003946, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their parent (A) who had stage one oesophageal cancer at the time of the complaint. A was admitted to hospital via the A&E and later diagnosed with pulmonary embolism (PE, a blockage of an artery in the lungs).

C complained that the board delayed in diagnosing the PE and that the care and treatment they provided to A was subject to delays and unreasonable. C was concerned that A had been incorrectly treated as a palliative patient when their cancer was not advanced and that should not have impacted the care A received.

The board apologised for the delay in diagnosing PE and for the delays to A's care that happened whilst they were an in-patient e.g. delay to x-ray being carried out. The board considered various aspects of A's care, such as, when they decided to use a nasogastric (reaching or supplying the stomach via the nose) feeding tube and the action they took to manage A's sepsis, to be appropriate at the time.

We took independent clinical advice from advisers with relevant experience. We concluded that the board failed to diagnose the PE when they should have, that they failed to carry out the x-ray when it should have been done, and that they delayed starting antibiotics to treat suspected pneumonia. We considered that if these delays did not happen, it is likely that A would not have needed to be admitted to a high dependency unit for care. We noted that the decision to use a nasogastric feeding tube was taken reasonably and in line with relevant guidelines.

In light of this, we found that there was an unreasonable delay in diagnosing PE and that there was a delay in starting antibiotics for suspected pneumonia. These delays likely led to A's condition worsening and contributed towards the requirement for A to be admitted to a high dependency unit. There were also communication failings that led to a delay in an x-ray being carried out.

We identified failings in the way in which the board handled the complaint. We found that the board's response to C's complaint did not address the matters raised in a structured format, which made it difficult to follow.

As such, on balance, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for the failings identified. 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:

- A suitable handover tool should be used consistently to ensure instructions have been carried out as

prescribed, e.g (SBAR) Handover Tool.

- Patients presenting with symptoms of pulmonary embolism should be diagnosed and treated in line with the relevant guidelines. Clinicians should be aware of confirmation/cognitive bias in differential diagnosis of patients with pre-existing conditions.
- Patients should be treated appropriately for their presenting symptoms and where appropriate antibiotic treatment commenced.

In relation to complaints handling, we recommended:

- Complaint responses should be clear and understandable, in line with the NHS Complaints Handling Procedure.

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.