SPSO decision report

Case: **202110880, A Medical Practice in the Grampian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the medical practice failed to provide their late parent (A) with reasonable care and treatment after A fell and hit their head. A had sustained a subdural haematoma (where blood collects between the skull and the brain). A was cared for in their home and later admitted to hospital. A died a few months after their fall.

We took independent advice on this complaint from a GP. We found that the head injury assessment was unreasonable and not in line with NICE guidance. We were critical that the practice did not acknowledge this failing in their complaint response, the significant adverse event review (SAER) or in response to our enquiries. We found that it was unreasonable that concerns raised by C, after A's fall, did not prompt further action by the practice. We also noted that the clinical notes did not adequately describe the head injury and there was no evidence that the practice understood the significance of the head injury and communicated that to the medical service they referred A onto. Therefore, we upheld this part of C's complaint.

C also complained that the practice unreasonably failed to carry out a SAER in line with the relevant Healthcare Improvement Scotland Guidance. We found that the initial SAER was of poor quality. The enhanced SAER was in line with the guidance, but we were again critical of the quality. Therefore, we upheld this part of C's complaint.

We also found that the practice's complaint handling did not mirror the current Model Complaints Handling Procedure. Therefore, we made a recommendation to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C 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:

- Significant adverse event reviews should be reflective and learning processes that involve the appropriate staff and ensure failings are identified and any appropriate learning and improvement is taken forward in line with relevant guidance.
- When a red flag situation is reported such as a head injury this should be appropriately assessed, including the presence/exclusion of red flags and documented in line with relevant guidance. If further symptoms are reported, all the available information should be considered and action taken as appropriate. Red flag situations such as a head injury should be appropriately reported to other agencies involved in the patient's care Head Injury: assessment and early management May 2023.

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.