SPSO decision report

Case: **202205973, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their spouse (A) received from the board whilst they were a patient of the cardiology ward. C complained that A collapsed on arriving home having been discharged after undergoing a coronary angiogram (a type of x-ray used to take pictures of the heart's blood vessels, the coronary arteries) and stenting procedure. A was found to have experienced a vascular complication (a large haematoma, where blood leaks from a large blood vessel) in front of the femoral artery (the main blood vessel supplying oxygen rich blood to the lower body) and had surgery to remove the haematoma. Following the second surgery, A developed an infection in the wound site.

The board said that due care was taken to weigh up the risks and benefits of various treatments in A's case. Whilst there were signs of a haematoma at the puncture site after the procedure, this was not increasing in size when A was discharged, and A's blood pressure was normal.

C complained to SPSO highlighting concerns about the decision to carry out an angiogram, the decision to discharge A, infection control and failures to follow protocol and use an ultrasound to assess the puncture site.

We took independent advice from an appropriately qualified consultant cardiologist. We found that carrying out an angiogram was appropriate in the circumstances. We considered the care and treatment following the procedure and on A's readmission to be reasonable. However, there were a number of factors which should have triggered staff to consider delaying discharge and seeking an ultrasound scan. We found that the need for an ultrasound scan was clinically indicated and that the decision to discharge was unreasonable. 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:

- The threshold for considering an ultrasound scan should be lowered for patients who have a higher bleeding risk and who develop painful haematomas post procedure. A lack of pulsatile haematoma should not preclude performing an ultrasound scan if there is clinical concern.

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.