SPSO decision report

Case: **202300714, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the board failed to provide reasonable care and treatment to their late parent (A). A became acutely unwell with uncontrollable diarrhoea, severe abdominal pain and vomiting. After visits from both a community nurse and out-of-hours GP, C called for an ambulance. The ambulance crew called ahead to the hospital to have A admitted, as per the board's alternative admission pathway. As agreed during the call, A was taken to the Acute Medical Unit (AMU) but there was no bed for A on arrival. Initial observations and ECG/bloods were taken but A was found unresponsive a short time later and died of a cardiac arrest.

The board apologised that no bed was available for A. They reviewed A's case and concluded that the appropriate referral pathway was followed. However, they acknowledged that patients with undifferentiated (undiagnosed) abdominal pain should not be admitted to the AMU.

We took independent advice from a consultant physician in acute and general medicine. We found that the board failed to obtain key information to determine which pathway should be followed. This resulted in A not entering the correct pathway. We found that the board failed to escalate A's care and treatment in line with relevant guidance and with their own policy. We found that A's care was compromised by the board's alternative admission pathway. It is possible that the outcome may have been different had the correct pathway been accessed. We upheld this part of C's complaint.

C complained that the board unreasonably failed to carry out a Significant Adverse Event Review (SAER) following A's death. After being notified of our investigation, the board commissioned a SAER. Although we welcomed this, the board did not provide assurance that they have adequate systems in place to identify, investigate and learn from adverse events. The board's failure to commission a SAER following A's death did not meet the standards outlined in the relevant guidance, and was unreasonable. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to carry out a SAER. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for the failings our investigation has 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:

- Patients should be admitted to the correct care pathway on the basis of their presenting symptoms. When accepting patients with undifferentiated gastrointestinal symptoms, local teams should be aware of the presence or absence of abdominal pain. Teams should ensure that they ask this specific question when

accepting patients.

- Patients should be managed in line with their presenting symptoms. Observations should be carried out in line with the board's escalation policy.
- There should be a robust process in place for reviewing all unexpected deaths, and, where appropriate, prompt commissioning of SAERs. Learning from these events should be disseminated and shared across teams in line with national guidance.

In relation to complaints handling, we recommended:

- Complaint investigations and case reviews should respond to all of the main points raised, identify failings where appropriate and take learning from what happened. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.

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.