# SPSO decision report

**Case:** **201102927, Ayrshire and Arran NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** not upheld, no recommendations


## Summary

Mr C has dementia. His wife (Mrs C) complained that the care and treatment provided to her husband by two hospitals was below a reasonable standard. She also said that when Mr C was reviewed by two doctors from an out-of-hours GP service they ignored her concerns that Mr C had a deep venous thrombosis (DVT – a blood clot in a vein). Mrs C also complained about a lack of communication from staff about Mr C's condition.

Mr C normally lived at home but in April 2011 he was in respite care when he became ill. His confusion increased and his mobility was affected. He was admitted to hospital but discharged three days later. Just over a week after he was discharged, Mrs C reported that Mr C was feeling terrible and had swollen legs and feet. He was seen on two consecutive days by GPs from the out-of-hours service. No definitive diagnosis was reached at either of these visits and Mrs C was given advice on managing Mr C's condition and to contact them again if his condition worsened. Mr C was, however, admitted to hospital again two days later, where DVT was diagnosed. He was transferred to another hospital, where he remained for three months before he was discharged.

We did not uphold Mrs C's complaints. Our investigation, which included taking independent medical and nursing advice, found no failings in the care and treatment provided to Mr C. Mrs C had been particularly concerned about two drugs given to her husband, an antipsychotic and a tranquiliser. Although more commonly used to treat mental illness, these drugs have been found to be useful, in low doses, for short periods under careful monitoring for those displaying the anxiety and agitation that can be a part of dementia. Our advisers were satisfied that the dosages were appropriate and that careful monitoring, dosage reduction and eventual withdrawal followed.

Our investigation found evidence of regular communication from staff to the family, in face to face or phone conversations. Mrs C complained that the family had had to seek out information and take the first steps in communicating with staff, but we found that it would be impractical and unreasonable to expect staff to always be proactive in communicating with patients' relatives. We found no evidence that the family were refused, or had any difficulty in obtaining, information about Mr C's condition.

Our investigation also found that the records showed that the out-of-hours GPs made appropriate and thorough examinations of Mr C. They considered DVT as a possible diagnosis but could make no definitive diagnosis at the time of the visits. Our medical adviser found no evidence of failure on the part of either GP.