SPSO decision report

Case: **201100243, Grampian NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that her late husband (Mr C) received from the board's out-of-hours service and in hospital. Mrs C said the response from the out-of-hours service was inappropriate, as the attendant arrived without batteries and sterile gloves and asked her to provide these. Mrs C also said she was refused an ambulance, and so took Mr C to hospital in her car. As there were no independent witnesses to the out-of-hours service's visit to Mrs C's home, we could not prove what took place. Therefore, in the absence of any direct objective evidence, we did not uphold this complaint.

Mrs C said the board failed to diagnose and treat her husband. We found from looking at the clinical records and after taking advice from one of our medical advisers that, although there were issues with a delayed gastroscopy and poor recording and communication about Mr C's' mobility, we could not conclude that the board failed to diagnose and treat him. We did not, therefore, uphold this complaint, although we made a recommendation related to it.

Mrs C said the board failed to record and/or pass on Mr C's wishes about resuscitation, and that Mr C was later resuscitated after a collapse. The board appeared to accept Mrs C's account that she was not given an indication that Mr C was ill enough for her to advise hospital staff of his wishes about resuscitation. However, when she felt his condition had deteriorated, she told a nurse, although the nurse did not record this or pass the information to medical staff. The board said there would be a review and confirmed to our office that nursing staff had been spoken to. As Mrs C's evidence was not disputed, we concluded that the board failed to record and/or pass on her husband's wishes about resuscitation and upheld this complaint.

Mrs C said the board provided poor general care. We found from looking at the clinical records and taking advice from one of our medical advisers that, while it was clear that the events of Mr C's final days were deeply upsetting for Mrs C

and her family, we could not conclude that the board provided poor general care to Mr C. We did not uphold this complaint.

Mrs C said there was poor communication from staff to her and her husband. We found there had been failings in communication and we upheld this complaint.

Finally, Mrs C said the board failed to order a post mortem to confirm the cause of death. We found from looking at the evidence, and taking advice from one of our advisers, that medical staff were confident of Mr C's final diagnosis and, therefore, there was no need for a post mortem. Our adviser agreed with this, in terms of Crown Office and Procurator Fiscal Service guidance and the clinical records. However, our adviser's view was that it was inappropriate for medical staff to presume what Mr C's wishes regarding a post mortem might have been, and that it would have been reasonable for them to have offered Mrs C the option of a hospital post mortem. However, as there was no requirement for the board to order a post mortem to confirm the cause of death in this case, we did not uphold the complaint.

Recommendations

We recommended that the board:

- ensure that clinical records document a patient's mobility, and that such information is communicated to relatives/carers on discharge;
- review their threshold for initiating discussions with patients/carers about resuscitation, given the record of a 'guarded' prognosis in this case; and
- review their practice on when a hospital post mortem should be offered to relatives/carers.