SPSO decision report

Case: **201200980, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the standard of nursing care that her late mother (Mrs A) received after she was admitted as an emergency to hospital with shortness of breath, unexplained weight loss and dehydration. Mrs A was diagnosed with cancer of the oesophagus (gullet) and died four days later after a cardiac arrest. Ms C complained about 16 incidents in the hospital and about aspects of her mother's care.

We took independent advice on this case from one of our medical advisers. She noted 13 areas where the board had acknowledged failings on their part, apologised and said that they had taken or would take appropriate remedial action. In the remaining three areas, the adviser said that when a patient was admitted with dehydration, a five hour wait for intravenous fluids was unacceptable and she would have expected these to have been started in the emergency department. She also noted Ms C's concern about her mother's white blood cell count being low and that information from hospital staff suggested there was a delay in a blood transfusion. The adviser said the records showed that the transfusion started on the day of Mrs A's admission to hospital and was not delayed. On the final point, the adviser was critical that when Ms C was called to the hospital during the night because of her mother's deteriorating condition, no-one was asked to meet her at the hospital entrance and take her to her mother's ward.

The adviser said there was evidence of significant failings that led to a traumatic experience for Mrs A in her last hours of life and to her immediate family. We noted that the board had investigated and addressed Ms C's complaint and that statements from staff members appeared to contain important reflections about their care and treatment of her mother and suggested that they were truly sorry for their failings. As the board had already taken action in a number of areas, we made recommendations to reflect this.

Recommendations

We recommended that the board:

- provide Ms C with a written apology for failing to start her mother's intravenous fluids in the emergency department;
- feed back our adviser's views on this failing to relevant staff;
- consider what local arrangements are in place to ensure that distressed relatives arriving at night are welcomed/orientated to the ward areas;
- provide us with full documentary evidence of each of the remedial actions identified in our investigation (with the exception of the apologies); and
- provide us with an update to improvements in the ward in question in the areas set out in the quality improvement plan, and demonstrate that the issues have been addressed and that learning has taken place.