SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201204116, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained on behalf of his partner (Ms B) that the care and treatment provided to her late mother (Mrs A) was inappropriate. Mrs A, who lived in a care home, was admitted to hospital where she was diagnosed with pneumonia and treated with intravenous antibiotics (drugs to fight a bacterial infection, delivered straight to the patient's vein). Mrs A was discharged to her care home three days later with antibiotic tablets, but died suddenly in the early hours of the following morning.

Our investigation included taking independent advice from two of our advisers, a medical adviser and a nursing adviser. The medical adviser said that Mrs A's condition had improved while she was in hospital. Because she was returning to a care home, it was reasonable for the hospital to consider discharging her. However, there was clearly a lack of discussion with the family and the care home about Mrs A's ongoing care. Ms B was not aware that her mother had been in hospital until the care home phoned to tell her that Mrs A had died. The medical adviser was also concerned that there was a lack of communication with Mrs A about her treatment, including a medical decision not to attempt resuscitation if her heart or breathing stopped (DNACPR). There was also no evidence that Mrs A's mental capacity had been appropriately assessed. The nursing adviser said that there was a lack of communication between nursing staff and Mrs A's family and her carers in planning for her discharge, and a general lack of detail in the nursing notes.

Recommendations

We recommended that the board:

- ensure that relevant staff reflect on the medical adviser's comments in relation to the assessment of patients who lack mental capacity to make complex decisions about their care and treatment;
- issue a reminder to relevant staff of the requirement to keep clear, accurate and legible records;
- ensure that relevant staff reflect on the medical adviser's comments in relation to the completion of the DNACPR form;
- provide evidence that relevant staff have reflected on the specific reasons why there was a failure to communicate with the patient and her family; and
- apologise to Mr C and his partner for the failures identified during this investigation.