SPSO decision report

Case: **201205039, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained that the care and treatment provided to her late mother (Mrs A) by two hospitals was unreasonable. She said that Mrs A's transfer between the two was delayed; she had to wait some hours for a bed once transferred; she was not treated for possible blood clots; she was not given enough pain relief; and that nursing care was poor.

Mrs A had had a stroke and was undergoing rehabilitation, firstly in Ayr Hospital (a general hospital) and then in Ailsa Hospital (a mental health hospital). When Mrs A's condition started to deteriorate in Ailsa Hospital, her daughters were concerned and asked for a medical review with a view to transferring Mrs A back to Ayr Hospital. Ms C thought that Mrs A might have suffered another stroke. Mrs A was not, however, examined by a doctor (in this case, a psychiatrist) until that evening when, after consultation with Ayr Hospital, it was decided not to transfer her. The following day Mrs A's condition had deteriorated further and she was transferred, with the receiving doctors noting that she was very unwell and treating her for an infection. The board's standard admission documentation has a section for doctors to complete saying whether or not the patient is thought to be at risk of blood clots (deep vein thrombosis - DVT), but this was not completed.

Our investigation included taking independent advice from two of our advisers - a doctor specialising in elderly medicine, and a nurse. We found that there were problems with Mrs A's care in both hospitals, and we upheld some of Mrs C's complaints. Our advisers said that there was delay in obtaining a medical review in Ailsa Hospital, and that when the review did take place it was inadequate. There was also a delay in arranging to transfer Mrs A. The medical adviser said that when Mrs A was admitted to Ayr Hospital, consideration should have been given to her susceptibility to blood clots. National guideline 122 issued by the Scottish Intercollegiate Guidance Network (SIGN) recommends that patients who have mobility problems and illnesses such as infection - as in Mrs A's case - should be treated with preventative drugs to minimise the risk of developing blood clots. This did not happen in Mrs A's case, and she went on to develop blood clots.

We did not uphold Ms C's complaints about pain relief and general nursing care. Both advisers said that there was no evidence to demonstrate that these aspects of Mrs A's care were unreasonable.

Recommendations

We recommended that the board:

- provide the Ombudsman with evidence that staff training referred to in the board's response has now taken place;
- ensure that all staff involved in this complaint at Ailsa Hospital reflect on their practice in this area and discuss any learning points at their next appraisal;
- confirm that all the medical staff involved in this complaint at both hospitals reflect on their practice in this area and discuss any learning points at their next appraisal;
- as a matter of urgency, take steps to ensure that medical staff at Ayr Hospital complete admission

documentation in relation to DVT and fully take into account SIGN guideline 122 in their clinical practice; and

- ensure that relevant staff are reminded that complaint responses should accurately reflect the clinical situation of the patient involved.