SPSO decision report

Case: **201301180, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment given to his late father (Mr A) after he was admitted to Ayr Hospital. Mr A had respiratory (breathing) and kidney disease. When he was in hospital he said he did not wish, nor was he able to tolerate, non-invasive ventilation (help with breathing, using a facemask or similar device). He was also recorded as not for cardio-pulmonary resuscitation (DNACPR - a decision taken that means a doctor is not required to resuscitate the patient if their heart or breathing stops). After 24 hours of being fairly stable after admission, Mr A was moved to a general medical ward (Station 16) but he began to decline, and he died after his breathing stopped, although medical staff tried to resuscitate him.

Mr C said that Mr A's care and treatment plan were not discussed with his family. He was also unhappy that after being admitted to the Medical High Care Unit (MHCU) Mr A was then moved to a general medical ward. He said that the notes that accompanied Mr A were unclear, and that the ward was ill-equipped to deal with him. He was also unhappy that although DNACPR was recorded in Mr A's records, an attempt had been made to resuscitate him.

The complaint was investigated and all the complaints correspondence and Mr A's relevant clinical records were carefully considered. We also took independent advice from one of our medical advisers, who is a consultant in medicine for the elderly. Our investigation found that following Mr A's admission to hospital there had been confusion and uncertainty, particularly when he was transferred from the MHCU to the general medical ward (although it appeared that his condition had been discussed with his family). We found this uncertainty unacceptable, and also noted that the medical documentation was unclear regarding DNACPR, which led to unnecessary confusion at the end of Mr A's life.

Recommendations

We recommended that the board:

- make a formal apology for the confusion and uncertainty caused;
- conduct a Critical Incident Review/Significant Event Analysis and provide the Ombudsman with a copy of the outcome;
- audit the completion of Do Not Resuscitate and ward-to-ward transfer forms in the MHCU and Station 16;
- audit documentation and communication of care needs and care planning on these wards; and
- review their procedure regarding handover between wards (particularly from a higher environment to a lower one) to satisfy themselves that it is fit for purpose.