SPSO decision report

Case: **201305981, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the care and treatment that her late brother (Mr A) received during two admissions to University Hospital Ayr. She felt he was inappropriately discharged on the first occasion and that the board had not communicated adequately or provided appropriate treatment during his second admission. During that admission, Mr A died and, although Ms C explained that her family were aware that he had been most unwell, she felt the board's care was unreasonable.

As part of our investigation we took independent advice from one of our medical advisers. He explained that Mr A had been suffering from serious liver disease and the outlook for him was poor. However, it was unclear from the medical records why a proposed course of treatment during his first admission was not administered. The notes said Mr A would be given medication if a particular test result was above a certain level, which it was. On balance, therefore, we upheld Ms C's first complaint and made two recommendations.

In terms of Mr A's second admission, our adviser explained that in such situations it is difficult to decide when it is appropriate to move to palliative care (care to prevent or relieve suffering only). However, staff had acted in line with appropriate guidance. Although we recognised the significance of this for Mr A's family, we found no evidence that Mr A's care was unreasonable or of an unreasonable delay in moving to palliative care. The evidence about communication was limited, but our adviser said that the records pointed to conversations with Mr A's family that reflected his condition at those times. Although we took Ms C's concerns into account we did not find that the evidence, viewed as a whole, indicated that the board failed to communicate adequately. We did not uphold these complaints.

Recommendations

We recommended that the board:

- ensure the staff involved in this case reflect on the need to communicate and consider all relevant test results prior to discharge; and
- remind clinical staff of the importance of ensuring records reflect a patient's treatment plan, particularly where the plan changes (where reasonably practicable in the circumstances).