SPSO decision report

Case: **201401226, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C complained about the care and treatment his late wife (Mrs C) received at University Hospital Ayr. Mr C was concerned that mistakes had been made when his wife had attended A&E. In particular, he told us about his concerns in relation to the insertion of chest drains, the removal of oxygen and the loss of four pints (units) of blood. Mr C was also concerned about the standard of communication with him and his family and that, as a result of information given directly to his wife, she lost any fight for life.

During our investigation, we took independent advice from a consultant in respiratory medicine. The complaint was investigated and showed that the treatment given to Mrs C was reasonable and appropriate. While she had in total three chest drains inserted these were necessary according to the circumstances and as part of her symptoms. We found no evidence in Mrs C's medical records that she had lost four units of blood nor was there evidence that oxygen was removed. The advice we received was that the medical records demonstrated that Mrs C was closely monitored even a few hours before she passed away and that she was given the maximum treatment necessary. There was no evidence of service failure on the part of the board and we did not uphold the complaint that the treatment given to her was unreasonable.

The board accepted that there had been some failings in communication and while they met with Mr C and his son as a result of these failings we were concerned that there was no written record of the meeting. The board also explained that a medical decision was taken not to resuscitate Mrs C and this was discussed with her. While the advice we received was that it would be good practice to document that this would be discussed with the family when they were available, our adviser also said that Mrs C's critical condition and poor prognosis, including that she was too unwell to be considered transfer to the intensive care unit or for resuscitation, was communicated to Mr C and his family reasonably well.

Recommendations

We recommended that the board:

- remind relevant staff that it is good administrative practice to keep a record of any meeting held with a complainant as part of the complaints process.