SPSO decision report

Case: **201507445, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr and Mrs C complained about the care and treatment provided to their daughter (Ms A) at Ayr Hospital. Ms A had a complex medical history and had required several operations over the course of her life.

Ms A suffered repeated urine infections and underwent an operation for this in the hospital. During the operation, Ms A breathed in fluid from her stomach. She was admitted into the intensive care unit (ICU) and placed on a ventilator. Ms A deteriorated over the weekend and did not recover, and she died shortly afterwards in the ICU.

Mr and Mrs C complained Ms A's care was inconsistent and that there was an inadequate level of medical staffing over the weekend. Mr and Mrs C said they had been given contradictory accounts of Ms A's condition and it had been a shock when they were informed treatment was to be withdrawn from her. They believed this should have been discussed with them and that the way the staff broke the news to them was inappropriate. They also complained that, after she died, Ms A was left connected to drips and monitors, which they felt was inappropriate.

The board met with Mr and Mrs C following their complaint. They did not discuss Ms A's care and treatment but they apologised if staff had increased the family's distress through their language or actions.

We took independent advice from a consultant in intensive care medicine and a senior nurse. The advice we received was that the care and treatment was reasonable. The medical records showed an appropriate level of medical review, along with the correct treatment for Ms A's condition. We found that communication with Mr and Mrs C was appropriate. It was, however, unreasonable for the family to have been left with Ms A after she died, without any attempts by staff to ascertain their wishes. We found this had added significantly to the family's distress. Although the care and treatment was reasonable, the board had accepted there were failings in communication with the family. We found they had apologised appropriately but that they needed to provide evidence of the actions taken to prevent a recurrence. We upheld this part of Mr and Mrs C's complaint and made recommendations to the board.

Recommendations

We recommended that the board:

- provide evidence that the actions identified in Mr and Mrs C's meeting with the board (following their complaint) have been carried out; and
- remind nursing staff of the importance of establishing family members' wishes should a patient die whilst in the ICU.