SPSO decision report

Case: **201508506, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained to us about the care and treatment her late mother (Mrs A) had received in Ninewells Hospital before her death. In particular, she complained about the management of her mother's oxygen therapy immediately before her death. Mrs A had a number of health problems, including idiopathic pulmonary fibrosis (a lung condition that causes scarring of the lungs and where the cause is unclear). She was receiving oxygen therapy and a trial had indicated that she required a consistent high level of oxygen via a rebreathing mask (a mask that provides a high concentration and flow of oxygen and is used to provide patients with very specific oxygen needs).

However, a nurse had put in place a nasal cannula (two prongs that sit at the bottom of the nose and are more comfortable to wear, but which deliver a lower concentration of oxygen than a rebreathing mask), to allow Mrs A to eat her lunch and drink. A nurse had then observed Mrs A to be alert after lunch, but ten minutes later, Mrs A was found to be dead. She did not have the mask on at that time.

We took independent advice on Mrs C's complaint from a consultant in respiratory medicine. We found that, in general, the clinical treatment provided to Mrs A had been reasonable. However, the fact that her oxygen saturation had dropped to low levels when her oxygen had been disconnected several days earlier should have alerted medical staff to the fact that she needed oxygen via a rebreathing mask and not a nasal cannula. We found that her oxygen saturation levels should have been monitored during and after her lunch if the rebreathing mask was to be removed, although there was no clear evidence that Mrs A's death resulted from this. We upheld this aspect of Mrs C's complaint. We also upheld her complaint that the board did not respond reasonably to her enquiries and complaints in view of their delays in responding to her.

Recommendations

We recommended that the board:

- provide evidence that consideration has been given to establish how to prevent a repetition of this incident in the future;
- issue a written apology to Mrs C for the failings identified; and
- make complaints handling staff aware of our decision.