SPSO decision report

Case: **201600538, Ayrshire and Arran NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that her mother (Mrs A) received prior to her death in University Hospital Ayr. Mrs A underwent major surgery and experienced post-operative complications. She was transferred to the medical high care ward for non-invasive ventilation (NIV, assistance with breathing using a mask). She had difficulty tolerating this treatment and it was recorded that she refused to continue with it. The family were called to come to the hospital and when they arrived they requested that NIV treatment be further attempted. However, the doctor did not agree to this. Mrs C complained that Mrs A had been confused since her surgery and that she did not have the capacity to refuse treatment.

We obtained independent medical advice from a consultant physician, who found that the evidence in the records showed that Mrs A had capacity to withdraw consent for further NIV treatment. The adviser explained that while the doctor considered the family's wish for further NIV, it was reasonable for them to decide that this would not be appropriate in view of Mrs A's expressed wishes and her clinical condition. In light of this, we did not uphold this aspect of the complaint.

However, we found that the family should have been involved in the decisions about NIV at an earlier stage, which the board had already acknowledged and apologised for. The adviser also noted that the decision not to continue treatment could have been explained more clearly to the family. In particular, it was noted that Mrs A's condition was poor and that further treatment was very unlikely to have been successful. This should have been sensitively communicated to the family, when instead the decision appeared to have been explained to them solely in terms of Mrs A having declined treatment. The adviser noted that national NIV guidelines had since been updated to require an individualised patient plan to be recorded at the start of treatment, which documents the agreed measures to be taken in the event of NIV failure.

Mrs C also complained that it took the board almost two years to address the issues she raised. We agreed that there was an unreasonable delay in the board responding to the complaint, and that their initial investigation was not thorough and robust. When they subsequently reviewed their initial findings, they reached a different view. Mrs C was provided with a copy of this review but we considered that she should also have received a further response specifically addressing the issues she had raised. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the time taken to investigate her complaint and the contradictory responses she received.

What we said should change to put things right in future:

- Ensure that our findings are fed back to the doctor involved for reflection and learning.

- Review their NIV protocol in light of recent guidelines to ensure that the patient is involved wherever possible in formulating an individualised patient plan setting out the measures to be taken in the event of NIV failure.

In relation to complaints handling, we recommended:

- Review their arrangements for assessing new complaints to ensure that the level of investigation or review required is considered at an early stage.
- Review how their complaint procedure interacts with the procedure for reviews to ensure that the complaint response is not unduly delayed by the review and that a full response addressing the points of complaint is provided at the end of the process.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.