SPSO decision report

Case: **201603771, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment her father (Mr A) received at University Hospital Crosshouse. Mr A had cancer and was suffering from jaundice, requiring him to have bile drained from his body. Mr A had an Endoscopic Retrograde Cholangiopancreatography (ERCP) procedure (a procedure that examines the pancreatic and bile ducts) to try and drain the bile. After this he developed sepsis (a blood infection) and died in the hospital several days later.

We took independent medical advice from a consultant in gastroenterology and an intensive care consultant. We found that an ERCP procedure was the recommended and appropriate treatment to attempt to drain the bile and relieve Mr A's jaundice. Whilst we found that it was reasonable for staff to have carried out this treatment, we found that the procedure was unsuccessful as a result of the invasion of the cancer. The resulting undrained bile had led to Mr A developing sepsis, which is a recognised complication of this procedure. We also found that, although there were some delays in carrying out investigations, including the ERCP procedure, these delays were not unreasonable and did not affect Mr A's outcome. We noted that the surgical team could have recognised the deterioration in Mr A's condition more quickly, however, we found that this did not affect his outcome and found his overall medical management was acceptable. Taking account of the evidence and the independent advice we received from both advisers, we considered that, on the whole, the care and treatment Mr A received was reasonable and we did not uphold this complaint.

Ms C also complained that hospital staff had failed to communicate adequately with her and her family about the seriousness of Mr A's clinical condition and prognosis. We found that there should have been better communication with Mr A's family regarding the risks of an ERCP procedure and also regarding the severity of his illness and prognosis, in particular, when Mr A's condition deteriorated after the ERCP procedure. The board acknowledged that there were shortcomings in their communication with Mr A's family, for which they had apologised. They said that they had taken action to address these failings and we asked the board to provide us with evidence of this. We upheld this aspect of Ms C's complaint but, in light of the action the board had said they had taken, we did not make any further recommendations on this issue.

The gastroenterology consultant who we took advice from on this case commented that there were shortcomings in the level of detail and clarity of documented discussions with Mr A about his diagnosis and its management. We made a recommendation for action in relation to this.

Recommendations

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

- Discussions with a patient should be clearly documented with the relevant amount of clarity and detail.

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.