SPSO decision report

Case: **201607982, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, who works for an advocacy and support service, complained on behalf of her client (Mrs B) about the care and treatment provided to Mrs B's late husband (Mr A) when he was admitted to Dr Gray's Hospital. Mr A suffered from congestive heart failure and was admitted to the hospital due to feeling tired and unwell, having chest pain, weight gain, nausea and vomiting. Ms C complained that the medical care and treatment provided to Mr A was unreasonable, and that he was not discharged in a reasonable way.

We took independent advice from a consultant physician. We found that, whilst overall assessments of Mr A and the general care and treatment provided to him was of a reasonable standard, there were gaps in weight monitoring. We noted that the board had previously addressed this matter. We also found that the issue of Mr A's internal defibrillator (a small device implanted into the body used to treat abnormal heart rhythms) was not recorded as having been discussed when a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR - a decision taken that means a healthcare professional is not required to resuscitate the patient if their heart or breathing stops) was put in place, and that the general record-keeping around the DNACPR decision was poor. We upheld this aspect of Ms C's complaint.

With regards to Mr A's discharge, we found that it was not reasonable to discharge Mr A as he had only recently been changed from having his medicine administered intravenously (into a vein) to taking it orally, and he was still on supplemental oxygen therapy at the point of the discharge decision. The adviser was critical that these issues were not monitored further prior to Mr A's discharge. Therefore, we upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs B for failing to provide a reasonable standard of medical care and treatment to Mr A during his admission and for failing to ensure that Mr A was discharged in a reasonable way. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Discussions around de-activation of internal defibrillators should occur and be documented at the same time as discussions around DNACPR. DNACPR decisions should be adequately documented and should include the reason for the decision.
- Any switch from intravenous to oral medication should be checked to be effective, supplementary oxygen should be stopped and oxygen levels should be monitored prior to discharge.

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.