SPSO decision report

Case: **201705441, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C and Ms C raised their concerns about the care and treatment their late mother (Mrs A) received when she was admitted to University Hospital Crosshouse, in particular, about the clinical and nursing care and treatment Mrs A received. They also complained about the communication with their family and that the board had failed to handle their complaint in a reasonable way.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly) and a nursing adviser. We found that there had been a failure to identify how unwell Mrs A was and a delay in initiating a higher level of care. We considered that the clinical care Mrs A received was unreasonable and upheld this complaint. However, we noted that it was possible that Mrs A would have died even with appropriate care, given the severity of her illness.

In relation to the nursing care given to Mrs A, the board acknowledged that Mrs A would have found it difficult to use the call system. As a result of a fall that Mrs A had suffered, the board staff had been advised that all patients with any degree of cognitive impairment should not be left unassisted within the ward where they could not been directly seen by nursing staff. We were satisfied with the action taken by the board. We also found no failings on the part of nursing staff regarding Mrs A's dehydration and dietary intake, medicine administration and Mrs A's personal care. Therefore, we did not uphold this aspect of the complaint.

In relation to communication, while we found there was evidence of some good communication, we found that overall the communication was poor, particulary after it was clear to medical staff that Mrs A's condition had deteriorated. We also found failings in relation to the communication surrounding the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision. Therefore, we upheld this aspect of the complaint.

Finally, in relation to complaint handling, we found that the board had failed to comply with their complaints handling procedure and we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to the family for the failings in clinical care, communication and complaints handling. 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:

- Staff should recognise signs of deterioration in patients and actively manage this.

In relation to complaints handling, we recommended:

- Written responses should normally be sent within 20 working days of receipt of the complaint, or a revised timescale agreed with the complainant.