SPSO decision report

Case: **201804026, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C, an advocacy worker, complained on behalf of Ms B that the board failed to provide her late mother (Mrs A) with reasonable care and treatment at Aberdeen Royal Infirmary and that staff at the hospital failed to communicate adequately with Mrs A's family about her care and treatment.

Mrs A had been admitted to the hospital's intensive care unit with respiratory failure where she died. Mrs A had suffered from a number of chronic illnesses. We took independent advice from a consultant in emergency medicine. We found that the care Mrs A received was reasonable and in line with current guidelines and good clinical practice. The evidence available showed that, ultimately, Mrs A's failure to respond to the treatment was because of the seriousness of her condition, and not the treatment itself. We did not uphold this aspect of the complaint.

In relation to communication with Mrs A's family, we found that it was clearly recorded in the clinical notes that on Mrs A's admission there had been a discussion with her family. It had been explained that there was a very real risk that Mrs A would not survive the admission and why performing cardiopulmonary resuscitation (CPR, where the heart and/or breathing is restarted if it stops) would not be in her best interest. However, other than this initial conversation, in general, communication with Mrs A's family was very poor. In particular, the decision to extubate Mrs A (to remove a breathing tube) should have been discussed with her family prior to this taking place. Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms B and her family for the communication failures identified. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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

- Patients and their families should be involved in the decision-making process where appropriate and should receive regular updates. This should be recorded in the clinical records.

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.