Scottish Parliament Region: South of Scotland

Case 201001180: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospitals; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns regarding the treatment that her father (Mr A) received following admission to Ayr Hospital (the Hospital). Mrs C complained that staff of Ayrshire and Arran NHS Board (the Board) failed to explain the severity of Mr A's condition to family members and that, as a result of this, his family were not with him at his bedside when he died. Mrs C raised further complaints regarding the condition that Mr A's body was in when the family were allowed in to see him and the Board's handling of her formal complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to explain properly the nature of Mr A's condition to his family *(upheld)*;

(b) the Board failed to allow family members access to Mr A during the final hours of his life *(upheld)*;

(c) the Board failed to respect Mr A's dignity *(upheld)*;

(d) information provided by the Board in response to Mrs C's complaint was inaccurate *(upheld)*; and

(e) the clinical records were inaccurate *(not upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review their procedures for handing over the care of patients between consultants, with a view to ensuring that all relevant information has been shared with family members;	31 August 2011

(ii)	review the communication between the consultants and nursing staff in Mr A's case, with a view to identifying any failures in communication from consultant to nurse to family members;	31 August 2011
(iii)	give further consideration to Mrs C's comments on the presentation of Mr A's body and take such steps as they feel appropriate to prevent similar upset in the future;	31 August 2011
(iv)	take steps to ensure that advice provided to patients' family members is accurately recorded in the clinical records; and	31 August 2011
(v)	take steps to ensure that statements relied upon to respond to complaints are checked against documented evidence for accuracy.	31 August 2011

Main Investigation Report

Introduction

1. The complainant (Mrs C)'s father (Mr A) suffered a cardiac arrest and was admitted to Ayr Hospital (the Hospital) on 2 November 2009. Mrs C and her mother (Mrs A) attended the Hospital with Mr A but it was suggested that they return home whilst Mr A was treated and await news of any development in his condition. Mr A's condition deteriorated overnight and he died in the afternoon of 3 November 2009. Mrs C complained that Ayrshire and Arran NHS Board (the Board)'s staff did not inform her or her family of the change in Mr A's condition. Had they known about this, they would have gone to the Hospital to be with him. She was also dissatisfied with the level of information provided once she did attend the Hospital on 3 November 2009.

2. Mrs C raised her concerns about the information provided to her family in a formal complaint to the Board in January 2010. She also complained about the state that Mr A's body was left in when family members were allowed in to see him. Dissatisfied with the Board's response, Mrs C brought her complaint to the Ombudsman in June 2010.

3. The complaints from Mrs C which I have investigated are that:

(a) the Board failed to explain properly the nature of Mr A's condition to his family;
(b) the Board failed to allow family members access to Mr A during the final hours of his life;
(c) the Board failed to respect Mr A's dignity;
(d) information provided by the Board in response to Mrs C's complaint was inaccurate; and
(e) the clinical records were inaccurate.

Investigation

4. In order to investigate this complaint, my complaints reviewer reviewed all of the correspondence between Mrs C and the Board. He also reviewed Mr A's clinical records and documentation relating to the Board's internal investigation and sought the opinion of my professional medical adviser (the Adviser).

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft version of this report.

(a) The Board failed to explain properly the nature of Mr A's condition to his family

6. Mr A was admitted to the Hospital on 2 November 2009 following an out of hospital cardiac arrest. He was admitted to the Intensive Care Unit (ICU) from the Accident and Emergency department (A&E) at around 19:00. In her complaint to the Board, Mrs C stated that an A&E doctor had met her and Mrs A upon arrival at the Hospital and explained the treatment that Mr A would receive. It was also explained that Mr A's prognosis was poor, given his condition at the time and his medical history.

7. After Mr A's transfer to the ICU, Mrs C and Mrs A were met by a charge nurse (the Charge Nurse). Mrs C said that the Charge Nurse explained the treatment that Mr A would be receiving and advised that his heart was 'fine'. My complaints reviewer found no record of this conversation within Mr A's clinical records. The Board advised my complaints reviewer that they had spoken to the Charge Nurse regarding Mrs C's comments, however, the Charge Nurse could not recall the precise details of the conversation. In a letter to Mrs C dated 18 February 2010, the Board apologised if the Charge Nurse's comments were misleading.

8. Mrs C and Mrs A were asked to wait while Mr A settled in to the ICU. Upon being allowed in to see Mr A, they met with an ICU nurse (Nurse 1). Nurse 1 suggested that Mrs C and Mrs A go home. She said that she would contact them should there be any change in Mr A's condition. In a subsequent written statement, Nurse 1 explained that she felt that Mrs A looked exhausted. She said that she advised Mrs C and Mrs A that they could contact the ICU at any time throughout the night for updates.

9. Mrs C told my complaints reviewer that she and Mrs A contacted the ICU regularly throughout the night for updates. She said that they were advised that Mr A's condition was 'stable'. When Mrs A telephoned on the morning of 3 November 2009, she was told that his condition was 'stable-ish'. Mrs A was advised that family members could visit Mr A after 11:00, once ward rounds had been completed.

10. Mr A's clinical records show that around 02:30 on 3 November 2009, he was found to have blood 'pouring from mouth'. He was given a nasogastric tube to drain fluids from his stomach. He was also given a blood transfusion.

11. At 09:00, the consultant treating Mr A (Consultant 1) finished his shift and treatment was taken over by a different consultant (Consultant 2). Notes made by Consultant 2, recording his initial assessment of Mr A's condition state: 'on adrenaline, so by definition he is in cardiogenic shock [inadequate blood circulation due to failure of the heart], and nowhere to go as he is not a candidate for IABP [intra-aortic balloon pump] or assist devices etc'.

12. Members of Mr A's family returned to the Hospital around 11:00 on 3 November 2009. Upon arriving at the ICU they were told that Mr A was receiving a bed-bath and that they should return in 45 minutes. In her complaint to the Board, Mrs C explained that she was relieved to learn that Mr A was receiving a bed-bath, as this, along with the previous night's advice that his heart was 'fine' gave her the impression that Mr A's condition had improved. In their response to Mrs C's complaint, the Board explained that it is normal practice for patients in the ICU to receive bed-baths, where their condition allows, as this enables staff to check the patient's skin and prevent the development of pressure sores.

13. When investigating this complaint, my complaints reviewer asked the Adviser to review Mr A's clinical records and the complaint correspondence between Mrs C and the Board. With regard to the Board's comments concerning bed-baths and the reasons for their use, the Adviser was satisfied with the explanation provided and noted that this would not be a sign of recovery. My complaints reviewer asked the Adviser whether she would expect nursing staff to provide more detail as to why Mr A was receiving a bed-bath. The Adviser did not consider that it would be necessary or appropriate for nursing staff to provide such detail about the reasons for bed-bathing and their significance in the overall scheme of care.

14. As requested, family members returned to the ICU following Mr A's bed-bath. Mrs C said that she knocked on the door and they were allowed in, on the basis of two visitors at a time. She and Mrs A went into the ICU to find that Mr A was fitting, losing blood and was making what Mrs C described as 'choking sounds'. Mr A's clinical records indicate that he had a further, sudden, large bleed at this time.

15. Mrs C said that she and Mrs A were given no information regarding what was happening until a nurse (Nurse 2) joined them at Mr A's bedside and

advised that Consultant 2 wished to speak to them. In their response to Mrs C's formal complaint, the Board explained that it is normal practice for nursing staff to meet family members outside the ICU to explain the patient's condition prior to entering. The Board apologised to Mrs C that this did not happen when she attended the ICU to visit Mr A. The Board told my complaints reviewer that a copy of Mrs C's complaint was shared with the ICU team and all staff were reminded of the standard of care expected of them in this regard.

16. Consultant 2 took Mr A's family members into a family room to discuss his condition. He reportedly advised them of the severity of Mr A's condition and commented that he 'won't see an hour'. Shortly afterward, while they were still in the family room with Consultant 2, another staff member entered and advised Consultant 2 that Mr A had died. Mrs C said that she found Consultant 2 to be 'cold, callous and arrogant' when advising that Mr A's condition had deteriorated and, later, when advising family members of his death.

17. Mrs C complained that the Board failed to inform her and her family of the seriousness of Mr A's condition and that this ultimately led to him being without his family in the final hours of his life. She said that, had family members been aware of his poor condition, they would have gone to the Hospital during the night to be with him.

18. My complaints reviewer asked the Adviser to comment as to when she would expect family members to be called in to hospital. The Adviser explained that the responsibility lies with the treating consultant to decide when family members should be contacted and asked to attend hospital. She said that the consultant in charge should arrange for family members to be called in when the patient's death is imminent.

19. My complaints reviewer also sought to establish the nature and extent of communications between the Board and Mr A's family throughout his time in the ICU.

20. In terms of communication with the Hospital, Mr A's clinical records contained one entry written by Nurse 1, recorded at 06:00 on 3 November 2009, which stated 'wife and daughter have telephoned overnight. Aware that little has changed overnight'. In a subsequent written statement, Nurse 1 also noted that various family members had contacted the Hospital throughout the night and she had advised that Mr A's heart had been fairly stable and that his

oxygen levels had improved. She stated 'Told a family member of the need for a nasogastric tube and blood when she telephoned after 3am. I did not at any time during my shift feel that [Mr A] had deteriorated or become unstable from an ICU nurse point of view to warrant his family being called to the Hospital'. Mrs C and her family were adamant that this telephone conversation did not take place.

21. The Adviser reviewed the clinical records and was generally satisfied that the available evidence showed a number of examples where ICU staff communicated with Mr A's family. She commented specifically on the information provided in Nurse 1's statement and felt that her suggestion that Mrs C and Mrs A return home on the night of 2 November 2009 was made with their best interests in mind. She also felt that the records made by Nurse 1 indicated a genuine belief that she was accurately reflecting Mr A's condition when family members called throughout the night. The Adviser noted that Mr A's condition deteriorated rapidly and considered that it may not have been apparent to nursing staff that there was a need to call his family in to the Hospital.

22. Consultant 2 also provided a written statement to assist the Board's internal investigation into Mrs C's complaint. He stated:

> 'I remember this man clearly. The manner of his death was distressing, and the family did not seem to me, to have been prepared for its likelihood. I only looked after him for a short while – having come on duty at 9am that morning. I noted his past cardiac history, his out of hospital arrest, his high dose of adrenaline, and his gastrointestinal bleeding. (I assumed his relatives would have been told how grave this all looked). I discussed the possibility of Endoscopy with [another consultant]. However events overtook us, with another massive GI bleed. His terminal decline occurred very fast and the relatives had to be called in from home. By the time I was explaining the situation to them, the man was dying.'

23. When commenting on a draft version of this report, the Board told my complaints reviewer that Consultant 2 asked for Mr A's family to be contacted at 11:00, which was the same time as the family arrived at the Hospital.

24. With regard to Mr A's bleed at 02:30 on 3 November 2009, the Board described this as an event in Mr A's treatment, rather than a change in his condition. They explained that the bleed was 'mild' and was not going to cause

Mr A to die. As such, they did not consider it necessary to contact Mr A's family and ask them to attend the Hospital at that time.

(a) Conclusion

25. Having reviewed Mrs C's complaint, it is clear how close she was to Mr A and how the circumstances surrounding his death continue to have an impact on her and her family's lives. In her complaint, she makes a direct connection between the Board's communication with Mr A's family members and the fact that they were not able to be at their father's bedside at the time of his death. The second issue is dealt with separately under complaint (b) of this report.

26. I acknowledge the Board's apology to Mrs C for any misleading information that may have been provided by the Charge Nurse upon her initial arrival at the ICU.

27. I accept the Board's and the Adviser's comments in relation to bed-baths.

28. I also share the Adviser's view that Nurse 1's suggestion that Mrs C and Mrs A return home on the night of 2 November 2009 was appropriate and I found it acceptable that they should be called in to the Hospital should there be any change in Mr A's condition.

29. It is clear that witnessing Mr A in such a state upon being allowed in to the ICU came as a shock to Mrs C and Mrs A and was a distressing experience for them both. I consider that, had nursing staff met Mrs C and Mrs A outside the ICU and explained what was happening, this may have better prepared them for what they would see. That said, I note the Board's apology to Mrs C in this regard and I am satisfied that appropriate action has been taken to prevent similar occurrences.

30. With regard to Mrs C's assertion that she and her family should have been advised of the deterioration in Mr A's condition and called in to the Hospital during the night, Consultant 2's written statement indicates that, upon taking over Mr A's care, he was aware of his poor prognosis. His comments suggest that he considered it appropriate for the family to have been notified of how grave the situation was and he evidently assumed that this had been done prior to his involvement. Consultant 2's records show that his opinion regarding Mr A's prognosis was, at least partly, based on events that had occurred around 02:30 on 3 November 2009.

31. I accept the Adviser's view that the consultant in charge should decide when family members should be contacted and that this typically occurs when the patient's death is imminent. This decision is a matter of professional judgement and, with hindsight, we know that Mr A's death was not imminent following his bleed at 02:30. I also acknowledge the Board's opinion that it was unnecessary to contact Mr A's family during the night due to the non-life-threatening nature of his bleed. Whilst it was for the treating consultants to decide whether the family should be called in, it is clear that the family made regular calls to the Hospital for updates on Mr A's condition. Information regarding changes in his condition or events in his treatment could have been provided during these conversations with hospital staff. Nurse 1 stated that a family member was made aware of Mr A's bleed and blood transfusion during the night, this is not recorded in the clinical records and the 06:00 entry states that the family were told that there was little change in his condition overnight.

32. I consider that each Consultant was responsible for ensuring that the family were made aware of Mr A's prognosis and I do not consider it acceptable for assumptions to be made that this information had already been provided. The evidence submitted to my complaints reviewer suggests that there was a failure in communication between Consultant 1 and Consultant 2 and, possibly, between the consultants and the nursing staff as to the extent of Mr A's condition. Whilst I did not find that the Board should have called the family in to the Hospital during the night, the available evidence suggests that the family could have been provided with more, or clearer, information as to the severity of Mr A's condition when they contacted the ward during the early hours of 3 November 2009 and when they arrived at the ward later that morning. Had this information been provided, they would have been able to decide for themselves whether to attend the Hospital. With this, and the communication issues already accepted by the Board in mind, I uphold this complaint.

(a) Recommendations

33. I recommend that the Board:	*Completion date*
(i) review their procedures for handing over the care of patients between consultants; with a view to ensuring that all relevant information has been shared with family members; and	31 August 2011

(ii)	review the communication between the consultants and nursing staff in Mr A's case, with a view to identifying any failures in communication from consultant to nurse to family members.	31 August 2011

(b) The Board failed to allow family members access to Mr A during the final hours of his life

34. Mrs C complained that she and other members of Mr A's family were not able to be with him at the time of his death. She felt that, had the Board explained to the family the severity of Mr A's condition, they would have attended the Hospital to be with him.

35. The events of the morning of 3 November 2009 are described under complaint (a) of this report. As I have already noted, upon arrival at the Hospital on 3 November 2009, family members were not immediately able to visit Mr A, as he was receiving a bed-bath. When family members returned to visit Mr A following the bed-bath, he was experiencing his second large bleed. Mr A died while family members were out of the ICU discussing his condition with Consultant 2.

36. My complaints reviewer asked the Board for details of their policy for allowing family members to be with patients in the ICU, when it is clear that the patient does not have long to live. They explained that their normal practice is to allow family members to be at the patient's bedside. The Board explained, however, that on this occasion it was felt that, whilst Mr A was critically ill and likely to die, there was sufficient time to appraise his family of the situation before allowing them to be with him. Due to the sudden onset of his second bleed, this was not ultimately possible.

37. The Adviser commented that it would be normal practice for family members to be allowed in to be with patients when it is known that their death is imminent. However, as Mr A experienced a massive bleed and required intensive emergency treatment up to the point of his death, it would not be appropriate for family members to be allowed at his bedside at that time.

(b) Conclusion

38. I recognise that the events of 3 November 2009 were extremely distressing for Mrs C and her family and note that she made a clear connection in her complaint between the Board's failure to communicate the severity of

Mr A's condition to family members and the fact that they were unable to be at his bedside at the time of his death.

39. The clinical records and comments from the Board and the Adviser all indicate that it was the suddenness of Mr A's second bleed that prevented the Board from following their normal procedure of allowing family members in to the ICU to be with the patient. The timing of the bleed was extremely unfortunate, as Mrs C and her family had been asked to return to the ICU after Mr A's bed-bath. It was following this bed-bath that he experienced the bleed. I do not consider it unreasonable for ICU staff to ask that visitors do not attend the ward during ward rounds and bed-bathing, as this is their normal procedure and there was no indication of the forthcoming sudden decline in Mr A's condition. Unfortunate timing again meant that Mr A died whilst Mrs C and her family were in the family room discussing his condition with Consultant 2.

40. I consider that the suddenness of Mr A's decline and the emergency care that he required resulted in the Board being unable to follow their normal procedures.

41. I concluded under complaint (a) of this report that the Board's communication was poor and that, had it been better, Mrs C and her family may have been better informed as to whether or not they should attend the Hospital earlier than 11:00. Although it was the suddenness and nature of Mr A's decline that led to Mrs C and her family not being able to be at his bedside at the time of his death, it is clear that, had Mr A's family been advised of the bleed that he experienced overnight and attended the Hospital earlier than 11:00, they may have been able to spend more time with Mr A. On balance, I uphold this complaint.

(b) Recommendations

42. My findings on this complaint are connected to the communication failures identified under complaint (a). As such, I have no further recommendations to make.

(c) The Board failed to respect Mr A's dignity

43. Following Mr A's death, Mrs A asked to see him. She and Mrs C were asked to wait outside while staff prepared his body. Upon being allowed to enter the room, they found that Mr A's hair, face, hand and arm had blood on

them. Mrs C complained that by failing to properly clean his body, the Board failed to respect Mr A's dignity.

44. In their response to Mrs C's complaint, the Board initially advised that nursing staff had been unable to remove all of the blood from Mr A's body. In a subsequent letter to Mrs C, they advised that staff were keen to allow family members in to see Mr A as soon as possible.

45. My complaints reviewer asked the Adviser whether, having asked the family to wait outside, nursing staff should have taken the time to fully prepare Mr A's body. He also asked how long, typically, it should take to complete last offices (preparation of the body). The Adviser explained that last offices can take up to two hours to complete, as a number of tasks are carried out in addition to cleaning the body. She said that a balance has to be found between making the body as presentable as possible and allowing family members in as soon as possible. The Adviser felt that the explanations provided by the Board were reasonable. She added that staff often try to allow the family in to see their relative as soon as possible after death with the intention of carrying out last offices after the family have left.

46. When commenting on a draft version of this report, the Board stated that Mr A's body was almost entirely cleaned, however, there was a further leakage of blood by the time the family were allowed in to see him. They explained that Mr A died of a massive bleed which covered his head and torso. As Mrs C noted, this stained his hair. The Board said that this was not resolvable in any reasonable timescale given the need to allow the family in to see Mr A's body. They apologised for any distress that this caused Mr A's family and if their staff failed to recognise that the family did not know what to expect upon seeing Mr A's body.

(c) Conclusion

47. I accept that a balance has to be struck between allowing family members in to see their relative as soon as possible and taking the time to carry out last offices. Nevertheless, in a situation like this I consider it important that family members are forewarned of their relative's appearance and that they are afforded the opportunity to choose to wait until last offices are complete before going in to be with them. This did not happen in this case and, on balance, I uphold this complaint.

(c) Recommendation

48. I recommend that the Board:	*Completion date*
(i) give further consideration to Mrs C's complaint about the preparation of Mr A's body and take such steps as they feel appropriate to prevent similar upset in the future.	31 August 2011

(d) Information provided by the Board in response to Mrs C's complaint was inaccurate

49. Mrs C raised concerns about the Board's response to her formal complaint, which focussed on the fact that Mr A's family had not been able to be at his bedside during the final hours of his life. They had been told to return home on the basis that the Board would contact them should Mr A's condition change.

50. Mrs C noted that Nurse 1 had been asked to provide a statement as part of the Board's internal investigation into her complaint. Nurse 1 stated: '[Mrs C] and various family members telephoned regularly overnight, the (sic) asked about his heart and I relayed that his heart had been fairly stable and that his oxygen levels had improved. I told a family member of the need for a nasogastric tube and blood when she telephoned after 3am.'

51. Mrs C said that the only female family members who contacted the Hospital through the night were her and Mrs A. Both of them denied being given this information by Nurse 1 and Mrs C felt that, had they received this information, the family would have attended the Hospital during the night.

52. Mrs C raised further concerns that, if Nurse 1 discussed Mr A's condition with a female caller around 03:00, this was not a family member. She considered that there could, therefore, be an issue in terms of patient confidentiality.

53. As Nurse 1's statement referred to an incoming telephone call, my complaints reviewer asked the Board what protocols they had in place to identify who is calling the Hospital. They explained that there was an expectation that staff would ask who is calling before giving out any information regarding patient care over the telephone. They noted that ICU staff were aware of this practice and should adhere to it at all times.

54. The clinical records held only one entry from Nurse 1 regarding contact with the family overnight. That note was recorded at 06:00 and evidently covered all telephone contact throughout the night, noting that the family were aware that there had been 'little change'.

(d) Conclusion

55. The information that Nurse 1 stated was provided is significant, as it relates to Mr A's first bleed at 02:30 and Nurse 1's statement suggests that she made Mr A's family aware of this development in his condition shortly afterward.

56. The note made by Nurse 1 at 06:00 does not detail what specific information, if any, was provided about the treatment Mr A had received. Nor does it record which family members had called the Hospital.

57. In the absence of any objective evidence, it is impossible for me to establish what information Nurse 1 provided during telephone calls received during the night, or to whom she may have provided that information. Accordingly, it is not possible for me to conclude with any certainty whether a member of Mr A's family was provided with this information, whether the information was provided to another individual, or whether the information was provided at all.

58. I consider the Board's practice for identifying incoming callers to be reasonable and would not consider it appropriate for staff to make further identification checks. That said, I found the corresponding clinical records to be rather brief and lacking detail as to the specific information provided and the individuals spoken to.

59. The key question when reaching a decision on this complaint is whether the statement provided by Nurse 1, and relied upon by the Board when responding to Mrs C's complaint, is inaccurate. I have given careful consideration to the documented records of telephone contact with Mr A's family and would have expected that if significant and detailed information relating to Mr A's need for intubation and transfusion had been provided as suggested, this information would have been documented. Given that it is not documented I have concluded, on balance, that this information most likely was not provided. I, therefore, uphold this complaint.

(d) Recommendations

60. I recommend that the Board:	*Completion date*
(i) take steps to ensure that advice provided to patients' family members is accurately recorded in the clinical records; and	31 August 2011
(ii) take steps to ensure that statements relied upon to respond to complaints are checked against documented evidence for accuracy.	31 August 2011

(e) The clinical records were inaccurate

61. When pursuing her complaint with the Board, Mrs C obtained a copy of Mr A's clinical records. She subsequently complained that the records were inaccurate. Specifically, she noted that the nursing notes were not written up in chronological order, that information was missing regarding the timing of certain events and that other entries did not have times against them. She also noted that Consultant 2 had completed a note stating that CPR (cardiopulmonary resuscitation) was performed, when he was with Mrs C at the time, and that Phenytoin (an anti-seizure medication) was planned to ease Mr A's seizures but was not detailed in the drug chart as having been provided.

62. My complaints reviewer asked the Board for details as to how ICU staff complete clinical records. He asked whether the notes are always made by the staff member whose actions they refer to, and whether they are completed at the time or retrospectively. The Board explained that clinical records should be updated at the time, or at the earliest opportunity thereafter, by the person involved. They should be accurately dated, timed and signed.

63. The nursing notes for 2 November 2009 were in order, however, those for 3 November 2009 showed entries at 06:00 before entries for 02:30. Each entry was numbered to show the correct order.

64. The nursing notes generally had times printed beside each entry and the correct date displayed. This was also the case for Consultant 1's notes, however, whilst Consultant 2's notes showed the correct date, the times that events took place were not recorded.

65. The note recorded by Consultant 2 regarding the use of Phenytoin was included in his initial assessment of Mr A upon taking over his treatment. This note set out a five-point treatment plan for Mr A, including the use of Phenytoin.

The Board confirmed to my complaints reviewer that Mr A was not given Phenytoin. This would have been administered had Mr A survived. As he did not survive, the drug featured in the treatment plan, but not in the drug chart.

66. With regard to Consultant 2's reference to CPR, the corresponding note stated 'Pronounced dead after inability to maintain output. Had 1 cycle CPR…'

(e) Conclusion

67. Having reviewed Mr A's clinical records, I found that the ICU notes were generally clear and relevant and were dated, timed and signed appropriately, with some exceptions. The nursing notes, whilst generally reflecting the events as we know them to have occurred, were clearly dated and signed, but the times in some cases did not appear to correspond to specific entries and were not always in chronological order.

68. The treatment plan set out by Consultant 2 had no time associated with it. The written statement that he submitted following Mrs C's complaint (see paragraph 22) indicated that further treatment was planned for Mr A but not actioned due to his sudden deterioration.

69. I did not find that Consultant 2's reference to CPR suggested that he had carried out the CPR. Rather, this note referred to the pronouncement of Mr A's death after CPR had been unsuccessful.

70. I found that the clinical records could have better recorded the timing of certain events and medication and I would draw this to the Board's attention. That said, I was satisfied that the entries made by staff accurately reflected Mr A's treatment and the action taken during his stay in the ICU. Accordingly, I do not uphold this complaint.

(e) Recommendations

71. I have no recommendations to make.

72. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's father
Mrs A	Mrs C's mother
The Board	Ayrshire and Arran NHS Board
The Hospital	Ayr Hospital
The Adviser	A professional medical adviser to the Ombudsman
ICU	Intensive Care Unit
A&E	Accident and Emergency department
The Charge Nurse	A charge nurse at the Hospital
Nurse 1	An ICU nurse at the Hospital
Consultant 1	An ICU consultant at the Hospital
Consultant 2	An ICU consultant at the Hospital
Nurse 2	An ICU nurse at the Hospital
CPR	Cardiopulmonary resuscitation