SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201406716, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C was concerned at the care and treatment given to her late mother (Mrs A) while she was a patient at University Hospital Ayr.

Mrs A had a history of heart problems and breathing difficulties and had not been eating. She had been vomiting for three weeks. She was admitted to hospital but her condition quickly deteriorated and she died a few days later. Mrs C believed that without her knowledge, her mother been placed on the Liverpool Care Pathway (LCP - an end of life care planning system for dying patients); that she was given too much fluid and that although diuretic treatment (medication to promote water loss from the body via the kidneys) was prescribed, it was not given. Despite complaining at the time, Mrs C said that action was not taken and as a consequence, Mrs A died. Mrs C also said that after she complained, she was told that her mother had been very seriously ill on arrival, however, she complained that she had not been given this information at the time.

We took independent advice from a consultant geriatrician and from a nurse practitioner. We established that Mrs A had not been placed on the LCP but we found a number of shortcomings with Mrs A's care and treatment: her medical and nursing records were not as complete as they should have been; there were failures in communication and staff did not properly engage with Mrs A and her family; medication was not administered and staff did not appear to have been alert to Mrs A's deteriorating condition. For all these reasons, we upheld the complaint.

Recommendations

We recommended that the board:

- make a formal apology for the clinical shortcomings identified;
- remind clinical staff involved in this case of their professional obligation to complete proper and detailed clinical notes;
- remind clinical staff involved in this case to communicate appropriately and in a timely manner with the patient and their family;
- ensure Mrs A's consultant considers this case as part of his next annual appraisal;
- make a formal apology for the nursing shortcomings identified;
- remind nursing staff of their professional obligation in so far as maintaining correct records in concerned;
- remind nursing staff of their professional obligation to communicate with family members; and
- reflect on the way the complaint was handled, particularly given its serious and significant nature, to prevent similar situations arising in the future.