SPSO decision report

Case: **201600074, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment his late wife (Mrs A) received at Crosshouse Hospital. Mrs A had been a patient there for 12 days when she was discharged home. Mrs A was readmitted to the hospital later the same day and died shortly thereafter.

We obtained independent medical advice and we found that although Mrs A was in an orthopaedic ward during her admission, she should have been admitted to a medical or rheumatology ward, or transferred to one as soon as possible after her admission. There was also a lack of a senior review of Mrs A by a consultant and a failure of early input from rheumatology, general medicine and microbiology. We found that the choice of antibiotics prescribed to Mrs A was a deficiency in her treatment, although we found no evidence that the antibiotics contributed to her decline. Furthermore, we found that there was a failure to act promptly on test results that showed Mrs A had E.coli. We also found that there were failures in communication with Mr C and Mrs A. While we found failings in Mrs A's treatment, we accepted that there were certain features that had masked the serious nature of her illness and that there was no significant error to blame for Mrs A's outcome. Given the failings identified, we upheld this part of Mr C's complaint.

Mr C was also dissatisfied that despite a post-mortem being carried out, Mrs A's death was recorded as unascertained. We found it was reasonable to record Mrs A's death as being unascertained given the advice we received that a post-mortem does not always provide a definite cause of death. We did not uphold this part of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should issue a written apology to Mr C for the failings in the care and treatment provided to Mrs A.

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

- The board should ensure that staff reflect on and learn from the findings of this investigation. In particular there should be reflection on the admission to an inappropriate ward, the antibiotic medication prescribed, the lack of early input from appropriate departments, the lack of senior review by a consultant, the lack of prompt action on test results and the poor communication.

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.