SPSO decision report

Case: **201603545, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: not upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his mother (Mrs A) at Biggart Hospital. Mr C complained that his mother was not provided with adequate care and treatment, specifically that alternative diagnoses to delirium were not considered and the delirium care pathway was not followed. Mr C also complained that Mrs A had wrongly been assessed as having the capacity to make decisions about her ongoing care, and that staff had acted unreasonably by failing to provide Mr C and his family with information about Mrs A whilst she was in hospital.

We took independent advice from a consultant physician and geriatrician. We found that the clinical care and treatment provided to Mrs A was of a reasonable standard. We noted that Mrs A was reviewed on at least a weekly basis, and that her physical and mental health were considered in detail throughout her stay. We also noted that alternative diagnoses were reasonably considered and that the care provided to Mrs A was in line with the board's delirium care pathway. We found that the board's assessment of Mrs A's capacity was reasonable. We also found that Mrs A's wishes regarding the sharing of her health information were documented several times throughout her admission and the board had acted reasonably in keeping information about her health confidential in line with her wishes. However, we did consider that the board could have communicated information regarding a second opinion from another clinician more clearly, and that it may have been useful for board staff to direct Mr C to an organisation that could provide him with advice and support.

Mr C also complained about the board's handling of his complaint. We found that whilst the target time for a response was not met by the board, they kept him informed of the delay and explained why it had occurred. We found this reasonable. We did not uphold any of Mr C's complaints, but we did make some recommendations.

Recommendations

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

- Communication with families around second opinions should be clear.
- When appropriate, staff should consider directing families to organisations such as the Mental Welfare Commission for advice and support.

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.