SPSO decision report

Case: **201607882, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the clinical and nursing care and treatment provided to her late husband (Mr A) when he was admitted to the University Hospital Ayr. We took independent advice from a consultant in emergency medicine, a consultant in acute medicine and a nursing adviser.

In relation to the clinical care and treatment provided to Mr A, having considered the available evidence and the advice provided to us we found that, overall, the medical care and treatment Mr A received was reasonable. The advice we received from the consultant in acute medicine was that Mr A's death was not preventable by the time he was admitted to hospital. We did not uphold the complaint. However, whilst the advice we received from the consultant in acute medicine was that cardiac monitoring would not have saved Mr A's life, they considered that the board should have a clear policy regarding which patients require cardiac monitoring. We made a recommendation regarding this.

Regarding the nursing care provided to Mr A, we found that there were gaps in the assessment and monitoring of Mr A and that the board wrongly focussed on anxiety being the cause of Mr A's shortness of breath. We also found that the guidance on using the Modified Early Warning Score (the monitoring of vital signs such as respiratory rate which helps alert clinicians to patients with potential for clinical deterioration or with established critical illness) was not followed, in that Mr A's Modified Early Warning Score was not repeated in line with guidance and there were gaps in the recording of his vital signs which was unreasonable. We further found that Mr A's Modified Early Warning Score should have been repeated on transfer to a new care area. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide a reasonable standard of nursing care and treatment to Mr A. The apology should meet the standards set out in the SPSO guidelines on apology available at https:/www.spso.org.uk/leaflets-and-guidance.

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

- There should be clear a policy regarding which patients require cardiac monitoring shared between the emergency department, the critical care unit and the acute medical unit.
- A Modified Early Warning Score should be checked within the recommended time frames. In line with good practice, a Modified Early Warning Score should be checked and documented when a patient is transferred to a new care area.
- When a patient or relative raises concerns about breathlessness, a Modified Early Warning Score should be rechecked and documented.
- Relevant staff should be aware of the importance of Modified Early Warning Score in anticipating

deterioration in a patient.

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.