SPSO decision report

Case: **202201376, Tayside NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A). A had been admitted to hospital before being transferred to a mental health facility. A then developed abdominal symptoms, which required them to be transferred to an acute hospital for treatment. A had been considered for surgery, but this was changed to treatment with medication. A was transferred back to the mental health facility but became unwell again and was taken to A&E. A died from a pulmonary embolism (a blood clot that blocks and stops blood flow to an artery in the lung).

C said that A's medical and nursing care fell below an acceptable standard which resulted in A's dignity being compromised, their personal care neglected and A not receiving the medication that they required. C believed that A's death was caused by a failure to examine A properly or ensure that A received anti-clotting medication. C felt that this resulted in A developing deep vein thrombosis (DVT, a blood clot in a vein) which led directly to their death. C was also unhappy with the board's response to their complaint. C felt that the board had not represented meetings with the family accurately, and failed to follow up on the actions that they had told the family were being taken, despite acknowledging that there was significant learning to be gained from the family's experience.

We took independent advice from a registered nurse and a consultant geriatrician (specialist in medicine of the elderly). We found that A's nursing and medical care had fallen below a reasonable standard. We also found that the board failed to communicate reasonably with C and their family and that they could not provide evidence that they had taken the actions promised to the family following the board's complaint investigation. In addition, the board's Significant Adverse Event Review had been delayed, reducing the utility of it to the board. We upheld all of C's complaints.

Recommendations

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

- All nursing staff on the relevant ward should be compliant with the board's medicine administration policy.
- An assessment by the medical team of the current rota and continuity of care based on the assurances given to A's family that staff numbers would improve this.
- Patient documentation completed to an appropriate standard, without sections left blank, this should include admission documents, care rounding charts, person centred care plans and delirium screening.
- The board should develop clear guidance to ensure patients with mental health issues can have timely access to nursing staff trained in mental health care, to reduce the reliance on family members providing care.
- The case should be discussed at the next available morbidity and mortality meeting.
- The medical staff involved should include this case for discussion at their next appraisal.

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.