SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201204558, Grampian NHS Board**
Sector: health
Subject: communication, staff attitude, dignity, confidentiality
Outcome: upheld, recommendations

Summary

Miss C's sister (Miss A) fell at home and was admitted to a hospital. Although she injured her back in the fall, her health had already been deteriorating for around two months. Miss A had a history of alcoholism and was underweight, and her GP had been treating her for urinary and lower respiratory tract infections. While in hospital, Miss A became lethargic and developed symptoms of liver disease. Although she initially responded well to treatment, her condition deteriorated and she was transferred to the care of liver specialists at a second hospital in a different board area. By that time Miss A was also suffering from pneumonia and increasing confusion, and she died two weeks after falling.

Miss C complained about the quality of nursing care at the second hospital, and the level of communication with family members. Specifically, she complained that she was not told that she could visit her sister outwith the standard visiting times, and that she was not contacted during the night when her sister's condition deteriorated. Miss C visited Miss A the following morning and found that she had died. She was unattended, with unconsumed medication on and around her bed.

We found the level of nursing care to be below an acceptable standard. Miss C should have been given clearer information about visiting times and should have been contacted when her sister's condition deteriorated. We accepted advice that, although Miss A's condition was closely monitored, staff should have identified that her deterioration was indicative of a terminal decline. Their failure to do so meant that Miss C was not able to be with her sister when she died. We also found that staff failed to provide adequate supervision of Miss A's medication intake.

Recommendations

We recommended that the board:

- apologise to Miss C for failing to make her aware of their flexible visiting arrangements and for failing to contact her when her sister's condition deteriorated;
- review their visiting policy to ensure that relatives are provided with information about visiting arrangements for patients who are critically ill;
- apologise to Miss C for failing to act on the changes to Miss A's vital signs during the night before she died;
- consider whether their nursing staff would benefit from refresher training on end of life care; and
- remind nursing staff of their responsibilities in line with section 2.10 of the Nursing and Midwifery Council Standards for Medicines Management.