SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201304171, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs A had been treated in the community for a urinary tract infection, confusion and dehydration, but the treatment did not address her condition and she went into Ayr Hospital for further treatment. Mrs A's daughter (Miss C) then complained on her mother's behalf about nursing care, prescribing of antibiotics (a range of drugs used to fight bacterial infection) and complaints handling.

During their complaints procedure, the board had already acknowledged some failings in the nursing care, and our investigation, which included taking independent advice from our nursing adviser, confirmed these failings. On balance, we upheld this complaint, although our nursing adviser explained that some of the nursing care and treatment was appropriate.

On one occasion during Mrs A's admission she required to be prescribed intravenous (directly into the vein) antibiotics and a medical review had been requested. There was a delay of four hours before a doctor attended to review her, and a further delay of seven hours before the antibiotics could be given as that doctor did not write up a prescription. We took independent advice from our medical adviser, who reviewed the evidence and was critical of these delays.

Miss C also complained that the board had not made a timely response to her complaint. Our investigation found that, while they did not respond within the 20 working days recommended in the NHS complaints handling procedure, there was no evidence of any avoidable delays and Miss C was kept informed. Although some of the communication with Miss C took place at her instigation, overall we found that the handling of her complaints was reasonable.

Recommendations

We recommended that the board:

- take action to ensure that all staff involved in this complaint are reminded of the need for effective communication with patients, relatives and carers;
- review their discharge procedures and documentation to ensure that relevant information is passed on to those involved in a patient's ongoing care; and
- issue a written apology for the additional failings identified during this investigation.