SPSO decision report

Case: **201304920, Ayrshire and Arran NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his mother-in-law (Mrs A) in Crosshouse Hospital before her death. Mrs A had dementia and had contracted clostridium difficile (C diff - a common healthcare-associated infection), which caused severe diarrhoea. Mr C complained that staff had failed to maintain Mrs A's personal hygiene. He said that they had not changed her often enough and that her hands were covered in her own faeces.

We took independent advice from our nursing adviser. The combination of Mrs A's dementia and severe diarrhoea had caused problems for staff and distress for her family. However, we found that staff had carried out frequent checks on Mrs A and had taken reasonable steps to maintain her personal hygiene. We did not uphold this aspect of Mr C's complaint.

Mr C also complained that staff failed to ensure that Mrs A's food or fluid was provided at the appropriate consistency. We found there had been problems with fluid consistency, and that there was delay in prescribing a dietary supplement. In view of these failings, we upheld this aspect of Mr C's complaint. However, the board sent us an action plan showing that refresher training on the provision of thickened fluids had been provided to staff. They had also apologised to Mr C for the shortcomings in Mrs A's care.

Finally, Mr C complained that staff failed to make adequate arrangements for Mrs A's discharge. We found that there should have been a multi-disciplinary meeting with social work and the family invited to attend before Mrs A was discharged, but that staff had failed to arrange this. In view of this, we also upheld this aspect of Mr C's complaint.

Recommendations

We recommended that the board:

- provide evidence that steps have been taken to ensure that, where appropriate, patients are promptly referred to the dietician for review;
- provide evidence to confirm that steps have been taken to ensure that, when appropriate, discharge planning meetings take place for patients in the ward and that relatives are included in the discharge planning process; and
- offer to meet with Mrs A's family to discuss the complaint and the steps taken to address the failings identified.