SPSO decision report

Case: **201305447, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C, who is an advocate, complained on behalf of her client (Mrs A) about the nursing and medical care provided to Mrs A's late husband (Mr A) at Dumfries and Galloway Royal Infirmary after he was admitted for a below-knee amputation. Mrs A was concerned that staff had not been monitoring Mr A's urine output or identified that fluid had been building up in his lungs. Mrs A felt that this caused Mr A to suffer a heart attack. After Mr A was discharged from hospital, Miss C complained to the board, however, there was a significant delay in the response being provided, by which time Mr A had died suddenly.

We took independent advice from two medical advisers, one a nurse and the other a consultant nephrologist (specialising in kidneys). We found that Mr A had a medical history of diabetes with multiple complications that had caused kidney damage in the past. Given this history, the medical complications he suffered (including a deterioration in kidney function, fluid collecting in the lungs, and a heart attack) were not unexpected. We did not find that the complications were a result of poor care and treatment, and so we did not uphold the complaint about medical care. However, there was no clear evidence to show that Mr A had been advised about the possible risk of cardiac problems given his medical history and we drew this to the board's attention. We also found that the nursing staff had not properly completed the fluid balance charts on a number of occasions, albeit the medical staff had carried out daily examinations for signs of fluid accumulation and managed the fluids and Mr A's medication appropriately. Therefore, we upheld Miss C's complaint about the nursing care Mr A received. We could not say for certain what had actually caused the heart attack but we made recommendations to address the failings in record-keeping.

In relation to complaints handling, the board accepted that they had delayed unreasonably in responding to the complaint. We were critical that there was a 13 week delay and made a number of recommendations to address the matter.

Recommendations

We recommended that the board:

- carry out an audit of patient medical records for the wards involved to ensure that fluid balance charts are being accurately completed;
- review their complaints procedure with a view to ensuring measures are in place to update complainants regularly in line with the guidance in the event that the 20 working day timescale cannot be met;
- remind all relevant staff dealing with complaints of the importance of updating complaints with the reason for any delays and their entitlement to contact us if the delay exceeds 20 days;
- apologise to Mrs A for the failings identified in the nursing care provided and complaints handling;
- take steps to ensure that the target timescale for dealing with complaints is met wherever possible; and
- ensure the nursing staff involved in Mr A's care are made aware of the importance of adequately assessing, monitoring and recording fluid balance.