SPSO decision report

Case: **201306298, Tayside NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Outcome: upheld, recommendations

Summary

Mrs C complained about the communication with her family during her late father (Mr A)'s admission to Cornhill Macmillan Centre for end of life care. She raised concerns that the family were excluded from most medical consultations and were not updated on changes to Mr A's condition or treatment. In particular, she complained that the family were not prepared for the fact that Mr A would not receive fluids once he was unable to take them orally. She said there was no continuity of care and there was no single member of staff who seemed to know Mr A well. She also complained that the visiting hours were overly strict, and that staff were defensive and did not support the family to make the most of Mr A's final weeks.

We obtained independent advice from a nursing adviser, who noted that aspects of Mr A's care appeared to be of a very good standard. The adviser said that a reasonable level of discussion with the family was documented, although she acknowledged that their needs did not appear to have been met in this regard. She considered that the family's concerns should have been picked up on early in Mr A's admission and support offered to them through a named individual. She noted that the board's assessment and decision-making in relation to fluid provision was well documented and appropriate to the circumstances. However, she considered that an early explanation to the family of the planned approach could have reduced their distress. The adviser also considered that the visiting policy was overly strict and outdated, when it should be flexible and adaptable to the individual needs of patients.

We were critical of the board that, after failing to resolve the concerns at the time, they did not use Mrs C's formal complaint to appreciate where things went wrong and identify specific learning opportunities. They developed an action plan in response to the complaint but we did not consider it to be robust enough. We felt that their response to the complaint was defensive and often missed the point of the issues being raised. We upheld the complaint.

Recommendations

We recommended that the board:

- further develop their action plan to take account of our findings and inform us of any learning and improvements that have taken place as a result of this complaint;
- consider providing training in early resolution skills, including difficult conversations, to staff involved in this episode of care;
- remind complaints handling staff of the importance of accurately assessing all issues raised, to ensure they are fully understood, and offering compassionate and understanding responses that clearly and specifically set out any learning that has taken place;
- review the visiting policy at Cornhill Macmillan Centre with a view to ensuring that it is person-centred and adaptable to the individual needs of patients and relatives; and
- apologise to Mrs C for the failings we identified.