SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201508085, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her husband (Mr A) during hospital admissions to the Royal Infirmary of Edinburgh (RIE), Liberton Hospital, the Western General Hospital and Ellen's Glen House in the months prior to Mr A's death. Mrs C also complained about communication and the board's complaints handling.

The board arranged a meeting for Mrs C with staff from the hospitals involved, and provided several written responses to her complaints, including an independent clinical review of some of the complaints. The board acknowledged a number of failings, including that significant decisions to complete a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form and a 'verification of expected death' form were not discussed with her or Mr A, that the nursing documentation from Ellen's Glen House was completed to a poor standard, and that all of the medical records from Mr A's admission to RIE had been lost. However, Mrs C was not satisfied with the board's response.

After taking independent medical and nursing advice, we upheld Mrs C's complaints. We found some additional failings in medical and nursing care, including that Mr A was discharged from RIE when he was not fit to be discharged, and that nursing staff did not contact the family or carry out a neurological assessment when Mr A suffered a minor head injury. In relation to Mr A's missing medical records, we were advised that the board's actions in relation to the management of files were relevant but not sufficient.

We also found failings in the board's complaints handling. On several occasions the board agreed to take action, but did not follow through on this, and the independent clinical review provided to Mrs C included inaccurate findings, which were contradicted by the board's later responses. However, in making our decision we acknowledged that the board devoted considerable time and effort to addressing the numerous points Mrs C raised, including meeting with her and writing detailed responses to her concerns.

Recommendations

We recommended that the board:

- feed back our findings to the RIE doctor who discharged Mr A, for reflection and learning;
- confirm that the consultant who put in place the DNACPR without informing Mrs C has discussed this complaint at an annual appraisal;
- demonstrate that there are robust auditing processes in place at Liberton Hospital and Ellen's Glen House, to ensure decisions about DNACPR and nurse verification of death decisions are discussed with patients and/or families;
- discuss the nursing adviser's comments in relation to the treatment of Mr A's head wound with relevant nursing staff, for reflection and learning;
- demonstrate they have taken the action identified in their improvement plan to improve record-keeping (introduction of transfer letters and discussion of the process of filing notes at a quality meeting);
- review training needs of relevant staff in relation to information governance;

- update the management of misfiled and missing records procedure to include reporting responsibilities of staff;
- apologise to Mrs C for the additional failings our investigation found;
- review their systems for tracking actions agreed with a complainant, to ensure they follow up on these; and
- confirm that the failings in the independent clinical review have been fed back to the relevant doctor for reflection and learning as part of their next annual appraisal.