SPSO decision report

Case: **201508092, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her father (Mr A) following two admissions to Glasgow Royal infirmary. Mr A, who resided in a nursing home, had vascular dementia and visual impairment. Ms C also complained about the time taken by the board to investigate and respond to her complaint.

During our investigation, we obtained independent medical and nursing advice.

Mr A was admitted to hospital after sustaining a fractured hip in a fall. He had surgery the following day and was discharged back to his nursing home several days later. The board accepted there were failings in Mr A's nursing care which had resulted in a failure to identify the infection(s) which Mr A was developing and had led to his premature discharge. The advice we received was that Mr A's surgical treatment was reasonable and he was not able to undertake rehabilitation due to his mental state.

However, we identified a number of failings in Mr A's medical care, nursing care, and in communication with his family. These included failure by staff to ensure they had the relevant information to make an informed decision about Mr A's discharge, as well as failures in record-keeping and nutritional care. We also found that during the assessment, planning and delivery of Mr A's care, there was a failure to fully comply with the Adults With Incapacity Act and the Standards of Care for Dementia in Scotland. We therefore upheld this aspect of Ms C's complaint. The board had apologised for the failings in communication during this admission and said they had introduced a new relatives communication sheet, in relation to which the nursing adviser said there were advantages and disadvantages.

Mr A was readmitted to hospital the following day. While Ms C considered the quality of care Mr A received was generally satisfactory and often good, she was critical of certain aspects of his care and about his subsequent transfer to Lightburn Hospital.

We did not find evidence that the medical treatment Mr A received during this admission was of an unreasonable standard and so did not uphold this aspect of Ms C's complaint. Although we considered that aspects of Mr A's nursing care were carried out to a reasonable standard, we found staff failed to ensure that it was appropriately person-centred. We found failures in complying with the Adults with Incapacity Act and the Standards of Care for Dementia in Scotland and also in the communication with Mr A's family. We therefore upheld Ms C's complaint in this regard.

The board also accepted that the time taken to investigate and respond to Ms C's complaint was unreasonable, and so we upheld this aspect of Ms C's complaint. We considered that the board had provided Ms C with an appropriate apology for this and taken steps to address what had occurred.

Recommendations

We recommended that the board:

- apologise to Ms C for the failings in Mr A's care and treatment;
- feed back the comments of the advisers and the findings of this complaint to the staff involved for reflection and learning;
- report to us on the steps taken to address the failings identified by this investigation in relation to complying with the Standards of Care for Dementia in Scotland, both in relation to patient care and treatment and in communication with relatives/carers;
- feed back to relevant staff the comments of the nursing adviser concerning the use of a relatives communication sheet;
- report to us on the steps taken to address the failings identified by this investigation in relation to complying with the Adults With Incapacity Act (2000), with particular regard to capacity to consent to treatment;
- carry out an audit of early readmissions following discharge from the ward concerned so as to identify any further avoidable failures; and
- provide evidence that the issues identified in relation to complaints handling have been fed back to their complaints lead and shared with complaints staff.