SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201700232, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his late relative (Mr A) at Dr Gray's Hospital. Mr A was admitted to hospital following a referral from his GP with raised body temperature/fever, an irregular heart rate and a high National Early Warning Score (NEWS - an aggregate of a patient's 'vital signs' such as temperature, oxygen level, blood pressure, respiratory rate and heart rate which helps alert clinicians to acute illness and deterioration). Mr A's condition deteriorated over a few days and he was transferred to the high dependency unit where he died a short time later. Mr C complained that the board failed to provide a reasonable standard of both clinical care and nursing care to Mr A. He also complained that the board failed to respond to his complaint in a reasonable way.

We took independent advice from a consultant in acute medicine and a nurse. Regarding Mr A's clinical care, we found that there was poor documentation by medical staff and a lack of concern to Mr A's deterioration and failure to improve. We noted that the severity of Mr A's illness may have been underestimated. Therefore, we upheld this aspect of Mr C's complaint. However, we noted that the board had identified failings and had taken steps to address these.

In relation to Mr A's nursing care, we found that there were no shortcomings in personal care of pain assessment and monitoring or blood sugar monitoring. However, we noted that nursing care in relation to fluid balance fell below a reasonable standard and that there were omissions in the recording of NEWS scores. Therefore, we found that the board failed to provide a reasonable standard of nursing care and upheld Mr C's complaint.

Finally, Mr C complained that he did not receive a response to his complaint from the board until approximately five months after he submitted it. We found that the board did not keep Mr C informed of their progress and that there was an unreasonable delay in responding to his complaint. We upheld this aspect of Mr C's complaint. However, we noted that the board acknowledged that there was an unreasonable delay and apologised to Mr C.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and his family for failing to provide a reasonable standard of clinical and nursing care and treatment to Mr A.The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Deteriorating patients should have their vital signs checked and the appropriate guidance followed when NEWS scores escalate.
- Fluid balance charts should be completed and used appropriately by nursing staff.
- When a complaint response takes longer than 20 days and/or amended timescales for completion are not

met, the complainant should be kept updated on progress.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.