SPSO decision report

Case: **201702944, Ayrshire and Arran NHS Board**
Sector: health
Subject: nurses / nursing care
Decision: some upheld, recommendations

Summary

Mr C made a number of complaints about the care and treatment that his late wife (Mrs A) received in University Hospital Crosshouse. Mrs A had a complex medical history and was admitted in relation to a skin condition. Mrs A became increasingly unwell during her admission and developed hospital acquired pneumonia (an infection of the lungs). Mr C complained about the nursing care that Mrs A received. Mr C also complained about the medical care that Mrs A received in relation to the insertion of a central line (a tube placed by needle into a large, central vein in the body to administer drugs or take blood samples), prescription/management of fluids, how she came to develop hospital acquired pneumonia and the prescription of pain relief. Mr C was also concerned about the DNACPR (do not attempt cardiopulmonary resuscitation) that was in place for Mrs A and that no post-mortem was carried out following her death. Mr C also considered that the handling of his complaint by the board was unreasonable.

We took independent advice from a nurse in relation to Mrs A's nursing care. While we did not find failings in relation to many aspects of Mrs A's care, we found that the appropriate skin assessment had not been carried out following her admission. The adviser highlighted that appropriate care and assessment could have avoided a pressure ulcer that Mrs A later developed. We upheld this aspect of Mr C's complaint.

We took advice from a consultant in acute medicine in relation to Mrs A's medical treatment. We noted that most aspects of Mrs A's care had been reasonable and that Mrs A's very low weight on admission to hospital made management of her fluid balance difficult. We found no failings in relation to the prescription of pain relief. The adviser highlighted that hospital acquired pneumonia is a risk for all patients, but particularly those who are frail and bed-bound. However, we found that there was a lack of evidence of an appropriate consent process for the insertion of the central line. Therefore, we upheld this aspect of Mr C's complaint.

In relation the DNACPR decision, we found that this was appropriate in Mrs A's case and that there was evidence that it was discussed reasonably. We also found that there was no clear answer as to whether or not a post-mortem should have been carried out for Mrs A. Therefore, we did not uphold these aspects of Mr C's complaint. However, we did note that a care after death checklist had not been completed and made a recommendation to the board in light of this.

Finally, we found that the board's complaint response was not issued within the prescribed timescales and did not address all the concerns that Mr C raised. We upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to carry out appropriate pressure area assessment and care, for the failures around the consent process for the central line, and for failing to handle his complaint reasonably. The apology should meet the standard 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:

- The board should ensure that all registered nursing staff carry out appropriate assessment and monitoring of patients at risk of pressure ulcers.
- Appropriate consent should be obtained and documented or an adults with incapacity form completed to cover the insertion of a central line.
- The board should ensure that all relevant staff are aware of and complete the care after death checklist for every patient who dies.

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.