SPSO decision report

Case: **201704711, Glasgow City Health and Social Care Partnership**
Sector: health and social care
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

Ms C, an advocacy worker, made a complaint to the partnership on behalf of Mrs B, regarding the care and treatment provided to Mrs B's mother (Mrs A). Mrs A suffers from dementia and was an in-patient at Stobhill Hospital. Mrs B was concerned about the nursing care provided to Mrs A, in particular with regards to management of Mrs A's incontinence, use of restraint, and an incident which resulted in Mrs A breaking her hip. Mrs B also raised concerns that when Mrs A was moved to Glasgow Royal Infirmary for treatment of her broken hip, there were failings in nursing care. In particular Mrs B was concerned that Mrs A was not receiving her medication due to staff failing to administer it covertly (mixed in food).

We took independent advice from a mental health nurse and a general nurse. We found that the management of Mrs A's incontinence had been reasonable, and that there was no evidence to suggest that the incident in which Mrs A broke her hip could have been avoided or that this was due to an unreasonable level of care. However, we found that the relevant policy in relation to restraint was out of date. Therefore, we considered the nursing care at Stobhill Hospital to be unreasonable and upheld this aspect of Ms C's complaint.

In relation to nursing care in Glasgow Royal Infirmary, we found that there was a failure to follow the covert medication guidance, which was, in any case, out of date. We also found that there was a lack of adequate care planning taking Mrs A's dementia into account, and in particular a lack of multi-disciplinary planning involving Mrs B and an appropriate level of specialist input, which may have resulted in poor and inconsistent care. We also found that there was a lack of pressure ulcer care planning. Therefore, we upheld this aspect of Ms C's complaint.

Ms C also complained about the level of communication from the partnership with Mrs B in regards to Mrs A's care and treatment. We found that whilst there was communication from staff at both hospitals, there was no documentation regarding Mrs B's preferences for frequency of communication which would have been helpful given her role as welfare guardian. We also found that there was a failure to complete a 'Getting to Know Me' document (a document which aims to give hospital staff a better understanding of patients with dementia) for Mrs A. We upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs B for failing to provide reasonable nursing care and treatment to Mrs A at Stobhill Hospital and Glasgow Royal Infirmary, and for failing to communicate reasonably with Mrs B with regards to Mrs A's care and treatment. 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:

- The policy on Management of Violence and Aggression should be up to date.

- The Covert Medication Policy should be up to date. Patients who require to receive medication covertly should be cared for in line with the partnership's Covert Medication Policy and pathway. When medication is missed the potential impact and management of this should be assessed.
- Patients with dementia should have a care plan which records their care needs, and where appropriate involves the multidisciplinary team, family/representatives, and specialist input.
- Pressure ulcer risks should be assessed and managed appropriately.
- 'Getting to Know Me' documents should be completed for patients with dementia.

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.