

## SPSO decision report



**Case:** 201708038, Grampian NHS Board  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

Mrs C complained about the care and treatment provided to her late brother (Mr A), who had chronic obstructive pulmonary disease (a disease of the lungs in which the airways become narrowed) and a mental ill health condition.

Mrs C firstly raised concern about a home visit by an out-of-hours doctor a number of weeks before Mr A's death. We took independent advice from a GP adviser. We found that the doctor who visited Mr A performed a reasonable assessment of him and we noted that the record-keeping was of a high standard. The records showed that Mr A had very low oxygen intake and potential signs and symptoms of heart failure. In view of the symptoms and the presentation described by the out-of-hours doctor, we considered that immediate hospital admission should have been arranged. We did not find evidence that this happened and we considered that this was unreasonable. We upheld this complaint.

Mrs C also raised concern about the input of the Community Mental Health Team (CMHT) in the months leading up to Mr A's death and also felt that the board had reached inconsistent conclusions about whether Mr A was refusing assistance for his physical health in their respective adverse event review and complaint investigation. We took independent advice from a mental health nursing adviser. We found that the level of liaison between the CMHT and Mr A's GP was limited and ineffective, whilst we also identified shortcomings in the documentation. We did not consider that the board reached inconsistent conclusions in the adverse event review and complaint investigation; however, we considered that the board's investigations failed to give adequate consideration to the judgement that Mr A had capacity to make decisions about his physical health. We upheld this complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to offer and arrange hospital admission for Mr A following an assessment during a home visit; not giving adequate consideration to the judgement that he had capacity to make decisions about his physical health; and the limited CMHT liaison with the GP and the poor documentation of this. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/leaflets-and-guidance](http://www.spsso.org.uk/leaflets-and-guidance).

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

- Patients presenting with symptoms and signs of heart failure should receive investigations and treatment in line with national clinical guidelines.
- Where a member of a CMHT identifies concerns about a patient's physical health, they should liaise with the patient's GP in a systematic and effective way and this should be documented in the mental health records.

In relation to complaints handling, we recommended:

- Investigations should objectively evaluate the merits of clinical decisions made.