SPSO decision report

Case: **201708977, Tayside NHS Board**
Sector: health
Subject: nurses / nursing care
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her father (Mr A) during two admissions to Ninewells Hospital. Mrs C complained about nursing care, medical treatment, surgical treatment, communication, and complaint handling.

During our investigation we took advice from a nurse, a consultant in acute medicine, a dermatologist (a specialist in diseases of the skin, hair and nails), a plastic surgeon, and a vascular surgeon (a clinician who treats disorders of the circulatory system).

In relation to nursing care, we found that there had been failings in relation to wound assessment and management; pressure ulcer prevention and management; mouth care; medication administration; adhering to fluid balance; and involving palliative care specialists. We were also concerned that the board's own investigation had not identified these failings. We upheld Mrs C's complaint about nursing care.

In relation to medical treatment, we found that many aspects of this were reasonable and that dermatology care was of a very good standard. However, we identified that there was a delay of around 12 hours in Mr A receiving antibiotics at one point and on this basis, we upheld this aspect of Mrs C's complaint.

We found that the surgical treatment provided to Mr A by both plastic and vascular surgery was reasonable and did not uphold this aspect of Mrs C's complaint.

With regard to communication, we found that the communication between the different teams and clinicians had been of a good standard. We also found that in general, there was good communication with Mr A and his family. However, at a point when Mr A's condition was deteriorating and it was unclear how much information he could understand and retain, there was a gap in communication with his family and we considered this to be unreasonable. We therefore upheld this aspect of Mrs C's complaint.

We considered the board's handling of Mrs C's complaint. We found that there were significant and unacceptable delays throughout the complaints process, and that communication from the board was reactive rather than proactive. We also found that there were a number of failures or delays in answering Mrs C and her family's questions. We considered the handling of Mrs C's complaints to have been unreasonable and we upheld this aspect of her complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide reasonable nursing care to Mr A; failing to provide reasonable medical treatment to Mr A; failing to reasonably communicate in relation to Mr A's care and treatment; and failing to handle Mrs C's complaint in a reasonable and timely manner. 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:

- Wounds should be assessed and managed appropriately and timeously, and in line with relevant guidance.
- Pressure ulcer prevention and management should meet the Healthcare Improvement Standards for Pressure Ulcer Prevention 2016.
- Mouth care should be carried out frequently, especially in patients who are not eating or drinking well, and if problems develop they should be addressed in a timely manner.
- Medication should be administered in accordance with the Nursing and Midwifery Code and the board's own local policy on prescribing and administration of medication. Where medications are not administered reasons for this should be documented.
- Accurate fluid balance and adherence to fluid restriction should be a priority in patients who have renal failure.
- Patients such as Mr A should be reviewed by palliative care staff in a timely manner, and efforts should be made to make patients comfortable during the end of life period.
- Action should be taken in a timely manner when a patient develops a new fever, and antibiotics should be commenced promptly.
- It should be documented if a patient is able to understand and retain information, and if not, communication with relevant family members should take place and be documented.

In relation to complaints handling, we recommended:

- Complaints should be handled in a reasonable and timely manner, and in line with complaint handling guidance.
- The board's complaints handling system should ensure that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement.

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.