SPSO decision report

Case: **202008878, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Nurses / nursing care
Decision: some upheld, recommendations

Summary

C raised complaints about the nursing and medical care their parent (A) received whilst in hospital. English was not A's first language and C also raised complaints about the board's communication with A and their family and whether appropriate follow-up care was provided by the board following C's discharge.

The board had accepted that A's nursing care fell below a reasonable standard in several areas, including the standard of record-keeping, the failure to discuss A's personal care with their family, and the assumptions that were subsequently made about A's preferences in relation to this. The board provided us with the nursing action plan they had developed following C's complaint. We took independent advice from a clinical nurse lead and a consultant geriatrician (specialist in medicine of the elderly). We found that the board's actions and action plan had been reasonable overall but there were some areas where the action plan could be improved. We upheld this part of C's complaint.

Similarly, the board accepted that the standard of communication with A and their family fell below a reasonable standard and had apologised for this. We found that the board's verbal and written communication could have been significantly improved, including their record-keeping. While the majority of issues were addressed by the action plan, there were some specific issues where staff could receive further feedback. We upheld this part of C's complaint.

C had been specifically concerned about modifications to A's medication and monitoring and treatment of A's feet. We found that the board's actions in relation to these had been reasonable and that A's medical care had been, overall, reasonable. We did not uphold this part of C's complaint.

Finally, the board had acknowledged their management of A's discharge and the communications associated with it, fell below a reasonable standard and had taken action with the aim of preventing any recurrence of this. We found that the actions proposed by the board largely addressed the issues involved. Therefore, we upheld this part of C's complaint and made only one further recommendation.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family, via C, that they failed to communicate appropriately with A and their family during A's admission, that they failed to provide A with a reasonable standard of nursing care whilst in hospital and for the failure to respond fully to all the issues raised in their complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Ward nursing staff communicate with patients and families appropriately, in line with the following sections

of the NMC code: Prioritise people, Practice effectively, Preserve safety, Promote professionalism and trust. Keep clear and accurate records relevant to your practice.

- Ward nursing staff are aware of the need to properly document patients' foot care as detailed in the The Activities of Daily Living Assessment and reinforced in the NHS Education for Scotland online module for CPR for feet.

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.