SPSO decision report

Case: **202102546, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their adult child (A) during two admissions to Aberdeen Royal Infirmary where they had been admitted for investigation and treatment of persistent vomiting and weight loss. We took independent advice from a nurse and asked for their comments on A's care and treatment during both admissions.

During the first admission, C complained about A being given incorrect medication, comfort and observation charts being completed inaccurately, and of the poor level of cleanliness in the ward's bathroom. We found that there were failings in these areas, which the board had acknowledged in their own complaint investigation and had identified actions for improvement and learning. Therefore, we upheld this aspect of C's complaint and asked the board to provide evidence of the actions that they had said they planned to take.

During the second admission, C complained that A was given the wrong nasogastric feed and failed to take proper action when A self-harmed; was provided with the wrong type of feeding tube; staff failed to communicate properly with C or A during the admission; and A was not given medication on discharge.

We found that the care of A's enteral feed (feeding tube leading into the stomach) to be reasonable, however we found that the planning and documentation of A's care after they had self-harmed was unreasonable. We also found that A had been given the wrong length of feeding tube and that the procedure went ahead despite this being known. Therefore, we upheld these aspects of C's complaint.

We found that communication with A had been reasonable and we did not uphold this aspect of C's complaint. In relation to communication with C, we found this to be mostly reasonable, however there had been a serious oversight in communicating with C when A had self-harmed. Therefore, on balance, we upheld this aspect of C's complaint.

In relation to A's discharge, we found this to be reasonable and we did not uphold this aspect of C' complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and C for the failings we have identified. 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:

- The board should ensure staff are aware of how to report and respond to incidents of self-harm when they occur within acute care settings.
- The board should ensure the correct type of feeding tube is used according to the planned procedure.

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.